2 Box 1 - JGR/Abortion (2) - Roberts, John G.: Files SERIES I: Subject File

SUPREME COURT OF THE UNITED STATES

Nos. 81–746 AND 81–1172

CITY OF AKRON, PETITIONER

81–746 *v.*

AKRON CENTER FOR REPRODUCTIVE HEALTH, INC., ET AL.

AKRON CENTER FOR REPRODUCTIVE HEALTH, INC., ET AL., PETITIONERS

81–1172 *v.*

CITY OF AKRON ET AL.

ON WRITS OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

[June 15, 1983]

JUSTICE O'CONNOR, with whom JUSTICE WHITE and JUSTICE REHNQUIST join, dissenting.

In *Roe* v. *Wade*, 410 U. S. 113 (1973), the Court held that the "right of privacy . . . founded in the Fourteenth Amendment's concept of personal liberty and restrictions upon state action . . . is broad enough to encompass a woman's decision whether or not to terminate her pregnancy." *Id.*, at 153. The parties in these cases have not asked the Court to re-examine the validity of that holding and the court below did not address it. Accordingly, the Court does not re-examine its previous holding. Nonetheless, it is apparent from the Court's opinion that neither sound constitutional theory nor our need to decide cases based on the application of neutral principles can accommodate an analytical framework that varies according to the "stages" of pregnancy, where those

Court to analyze the state regulations in these cases, cannot be supported as a legitimate or useful framework for accommodating the woman's right and the State's interests. The decision of the Court today graphically illustrates why the trimester approach is a completely unworkable method of accommodating the conflicting personal rights and compelling state interests that are involved in the abortion context.

As the Court indicates today, the State's compelling interest in maternal health changes as medical technology changes, and any health regulation must not "depart from accepted medical practice." *Ante*, at 12.[2] In applying this

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the first trimester." *Id.*, at 163. Before that time, "the abortion decision and its effectuation must be left to the medical judgment of the pregnant woman's attending physician." *Id.*, at 164. After the end of the first trimester, "a State may regulate the abortion procedure to the extent that the regulation reasonably relates to the preservation and protection of maternal health." *Ibid.* The Court noted "in the light of present medical knowledge . . . . mortality in abortion may be less than mortality in normal childbirth" during the first trimester of pregnancy. *Id.*, at 163.

The state interest in potential human life was held to become compelling at "viability," defined by the Court as that point "at which the fetus . . . [is] potentially able to live outside the mother's womb, albeit with artificial aid." *Roe*, *supra*, 410 U. S., at 160 (footnote omitted). Based on the Court's review of the contemporary medical literature, it placed viability at about 28 weeks, but acknowledged that this point may occur as early as 24 weeks. After viability is reached, the State may, according to *Roe*, proscribe abortion altogether, except when it is necessary to preserve the life and health of the mother. See 410 U. S., at 163–164. Since *Roe*, the Court has held that held that *Roe* "left the point [of viability] flexible for anticipated advancements in medical skill." *Colautti* v. *Franklin*, 439 U. S. 379, 387 (1979).

The Court has also identified a state interest in protection of the young and "familial integrity" in the abortion context. See *e. g.*, *H.L.* v. *Matheson*, 450 U. S. 398, 411 (1981).

[2] Although the Court purports to retain the trimester approach as "a reasonable legal framework for limiting" state regulatory authority over abortions, *ante* at 11, n. 11, the Court expressly abandons the *Roe* view that the relative rates of childbirth and abortion mortality are relevant for determining whether second-trimester regulations are reasonably related

the State must continuously and conscientiously study contemporary medical and scientific literature in order to determine whether the effect of a particular regulation is to "depart from accepted medical practice" insofar as particular procedures and particular periods within the trimester are concerned. Assuming that legislative bodies are able to engage in this exacting task,[4] it is difficult to believe that our Constitution *requires* that they do it as a prelude to protecting the health of their citizens. It is even more difficult to believe that this Court, without the resources available to those bodies entrusted with making legislative choices, believes itself competent to make these inquiries and to revise these standards every time the American College of Obstetricians and Gynecologists (ACOG) or similar group revises its views about what is and what is not appropriate medical procedure in this area. Indeed, the ACOG standards on which the Court relies were changed in 1982 after trial in the present cases. Before ACOG changed its standards in 1982, it recommended that all mid-trimester abortions be performed in a hospital. See *Akron Center for Reproductive Health, Inc.* v. *City of Akron*, 651 F. 2d 1198, 1209 (CA6 1981). As today's decision indicates, medical technology is changing, and this change will necessitate our continued functioning as the nation's "*ex officio* medical board with powers

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Services, Inc. v. *Orr*, 451 U. S. 934 (1981) is not, as the court below thought, binding precedent on the hospitalization issue. See *ante*, at 14, n. 18. Although the Court reads *Gary-Northwest* to be decided on the alternate ground that the plaintiffs failed to prove the safety of second-trimester abortions, *ibid*, the Court simply ignores the fact that the district court in *Gary-Northwest* held that "*even if* the plaintiffs could prove birth more dangerous than early second trimester D & E abortions," that would *not* matter insofar as the constitutionality of the regulations were concerned. See 496 F. Supp., at 903 (emphasis added).

[4] Irrespective of the difficulty of the task, legislatures, with their superior fact-finding capabilities, are certainly better able to make the necessary judgments than are Courts.

to believe that fetal viability in the first trimester of pregnancy may be possible in the not too distant future. Indeed, the Court has explicitly acknowledged that *Roe* left the point of viability "flexible for anticipated advancements in medical skill." *Colautti* v. *Franklin*, 439 U. S. 379, 387 (1979). "[W]e recognized in *Roe* that viability was a matter of medical judgment, skill, and technical ability, and we preserved the flexibility of the term." *Danforth*, *supra*, 428 U. S., at 64.

The *Roe* framework, then, is clearly on a collision course with itself. As the medical risks of various abortion procedures decrease, the point at which the State may regulate for reasons of maternal health is moved further forward to actual childbirth. As medical science becomes better able to provide for the separate existence of the fetus, the point of viability is moved further back toward conception. Moreover, it is clear that the trimester approach violates the fundamental aspiration of judicial decision making through the application of neutral principles "sufficiently absolute to give them roots throughout the community and continuity over significant periods of time . . . ." A. Cox, The Role of the Supreme Court in American Government 114 (1976). The *Roe* framework is inherently tied to the state of medical technology that exists whenever particular litigation ensues. Although legislatures are better suited to make the necessary factual judgments in this area, the Court's framework forces legislatures, as a matter of constitutional law, to speculate about what constitutes "accepted medical practice" at any given time. Without the necessary expertise or ability, courts must then pretend to act as science review boards and examine those legislative judgments.

The Court adheres to the *Roe* framework because the doctrine of *stare decisis* "demands respect in a society governed

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provement in the outlook for survival of small premature infants." Stern, *Intensive Care of the Pre-Term Infant*, 26 Danish Med. Bull. 144 (1979).

properly assert important interests in safeguarding health [and] in maintaining medical standards." 410 U. S., at 154. It cannot be doubted that as long as a state statute is within "the bounds of reason and [does not] assume[] the character of a merely arbitrary fiat. . . . [then] [t]he State . . . must decide upon measures that are needful for the protection of its people . . . ." *Purity Extract and Tonic Co.* v. *Lynch*, 226 U. S. 192, 204–205 (1912). "There is nothing in the United States Constitution which limits the State's power to require that medical procedures be done safely . . . ." *Sendak* v. *Arnold*, 429 U. S. 968, 969 (WHITE, J., dissenting). "The mode and procedure of medical diagnostic procedures is not the business of judges." *Parham* v. *J. R.*, 442 U. S., 584, 607–608 (1979). Under the *Roe* framework, however, the state interest in maternal health cannot become compelling until the onset of the second trimester of pregnancy because "until the end of the first trimester mortality in abortion may be less than mortality in normal childbirth." 410 U. S., at 163. Before the second trimester, the decision to perform an abortion "must be left to the medical judgment of the pregnant woman's attending physician." *Id.*, at 164.[6]

The fallacy inherent in the *Roe* framework is apparent: just because the State has a compelling interest in ensuring maternal safety once an abortion may be more dangerous in childbirth, it simply does not follow that the State has *no* interest before that point that justifies state regulation to ensure that first-trimester abortions are performed as safely as

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[6] Interestingly, the Court in *Danforth* upheld a recordkeeping requirement as well as the consent provision even though these requirements were imposed on first-trimester abortions and although the State did not impose comparable requirements on most other medical procedures. See *Danforth*, *supra*, 428 U. S., at 65–67, 79–81 (1976). *Danforth*, then, must be understood as a retreat from the position ostensibly adopted in *Roe* that the State had *no* compelling interest in regulation during the first trimester of pregnancy that would justify restrictions imposed on the abortion decision.

nature of the State's interference with it. *Roe* did not declare an unqualified 'constitutional right to an abortion,' . . . . Rather, the right protects the woman from unduly burdensome interference with her freedom to decide whether to terminate her pregnancy." *Maher*, *supra*, 432 U. S., at 473–474. The Court and its individual Justices have repeatedly utilized the "unduly burdensome" standard in abortion cases.[8]

The requirement that state interference "infringe substantially" or "heavily burden" a right before heightened scrutiny is applied is not novel in our fundamental-rights jurispru-

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[8] See *Bellotti* v. *Baird*, 428 U. S. 132, 147 (1976) (*Bellotti I*) (State may not "impose undue burdens upon a minor capable of giving informed consent." In *Bellotti I*, the Court left open the question whether a judicial hearing would unduly burden the *Roe* right of an adult woman. See 428 U. S., at 147.); *Bellotti* v. *Baird*, 443 U. S. 622, 640 (1979) (*Bellotti II*) (opinion of JUSTICE POWELL) (State may not "unduly burden the right to seek an abortion"); *Harris* v. *McRae*, 448 U. S. 297, 314 (1980) *supra*, 448 U. S., at 314 ("The doctrine of *Roe* v. *Wade*, the Court held in *Maher* 'protects the woman from unduly burdensome interference with her freedom to decide whether to terminate her pregnancy,' [432 U. S., at 473–474], such as the the severe criminal sanctions at issue in *Roe* v. *Wade*, *supra*, or the absolute requirement of spousal consent for an abortion challenged in *Planned Parenthood of Central Missouri* v. *Danforth*, 428 U. S. 52"); *Beal* v. *Doe*, 432 U. S. 438, 446 (1977) (The state interest in protecting potential human life "does not, at least until approximately the third trimester, become sufficiently compelling to justify unduly burdensome state interference . . . ."); *Carey* v. *Population Services International*, 431 U. S. 678, 705 (1977) (POWELL, J., concurring in part and concurring in the judgment) ("In my view, [*Roe* and *Griswold*] make clear that the [compelling state interest] standard has been invoked only when the state regulation entirely frustrates or heavily burdens the exercise of constitutional rights in this area. See *Bellotti* v. *Baird*, 428 U. S. 132, 147 (1976)."). Even though the Court did not explicitly use the "unduly burdensome" standard in evaluating the informed-consent requirement in *Planned Parenthood* v. *Danforth*, 428 U. S. 52 (1976), the informed-consent requirement for first trimester abortions in *Danforth* was upheld because it did not "unduly burden[] the right to seek an abortion." *Bellotti I*, supra, 428 U. S., at 147.

The "undue burden" required in the abortion cases represents the required threshold inquiry that must be conducted before this Court can require a State to justify its legislative actions under the exacting "compelling state interest" standard. "[A] test so severe that legislation can rarely meet it should be imposed by courts with deliberate restraint in view of the respect that properly should be accorded legislative judgments." *Carey*, *supra*, 431 U. S., at 705 (POWELL, J., concurring in part and concurring in the judgment).

The "unduly burdensome" standard is particularly appropriate in the abortion context because of the *nature* and *scope* of the right that is involved. The privacy right involved in the abortion context "cannot be said to be absolute." *Roe*, *supra*, 410 U. S., at 154. "*Roe* did not declare an unqualified 'constitutional right to an abortion.'" *Maher*, *supra*, 432 U. S., at 473. Rather, the *Roe* right is intended to protect against state action "drastically limiting the availability and safety of the desired service," *id.*, at 472, against the imposition of an "absolute obstacle" on the abortion decision, *Danforth*, *supra*, 428 U. S., at 70–71, n.11, or against "official interference" and "coercive restraint" imposed on the abortion decision, *Harris*, *supra*, 448 U. S., at 328 (WHITE, J., concurring). That a state regulation may "inhibit" abortions to some degree does not require that we find that the regulation is invalid. See *H.L.* v. *Matheson*, 450 U. S. 398, 413 (1981).

The abortion cases demonstrate that an "undue burden" has been found for the most part in situations involving absolute obstacles or severe limitations on the abortion decision. In *Roe*, the Court invalidated a Texas statute that criminalized *all* abortions except those necessary to save the life of the mother. In *Danforth*, *supra*, the Court invalidated a state prohibition of abortion by saline amniocentesis because the ban had "the effect of inhibiting . . . the vast majority of abortions after the first 12 weeks." 428 U. S., at 79. The Court today acknowledges that the regulation in *Danforth* effectively represented "a *complete* prohibition of abortions in

dressed the same problem." *Columbia Broadcasting System, Inc.* v. *Democratic National Committee*, 412 U. S. 94, 103 (1973).[10]

We must always be mindful that "[t]he Constitution does not compel a state to fine-tune its statutes so as to to encourage or facilitate abortions. To the contrary, state action 'encouraging childbirth except in the most urgent circumstances' is 'rationally related to the legitimate government objective of protecting potential life.' *Harris* v. *McRae*, 448 U. S., at 325. Accord *Maher* v. *Roe*, *supra*, at 473–474." *H.L.* v. *Matheson*, *supra*, 450 U. S., at 413 (footnote omitted).

IV

A

Section 1870.03 of the Akron ordinance requires that second-trimester abortions be performed in hospitals. The Court holds that this requirement imposes a "significant obstacle" in the form of increased cost and decreased availability of abortions, *ante*, at 16, and the Court rejects the argument offered by the State that the requirement is a reasonable health regulation under *Roe*, *supra*, 410 U. S., at 163. See *ante*, at 17.

For the reasons stated above, I find no justification for the trimester approach used by the Court to analyze this restric-

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[10] In his *amicus curiae* brief in support of the City of Akron, the Solicitor General of the United States argues that we should adopt the "unduly burdensome" standard and in doing so, we should "accord heavy deference to the legislative judgment" in determining what constitutes an "undue burden." See Br. of the Solicitor General, at 10. The "unduly burdensome" standard is appropriate *not* because it incorporates deference to legislative judgment at the threshold stage of analysis, but rather because of the limited *nature* of the fundamental right that has been recognized in the abortion cases. Although our cases do require that we "pay careful attention" to the legislative judgment before we invoke strict scrutiny, see *e. g.*, *Columbia Broadcasting System, Inc.* v. *Democratic National Committee*, 412 U. S. 94, 103 (1973), it is not appropriate to *weigh* the state interests at the threshold stage.

ardous, expensive, and emotionally disturbing for a woman than early abortions." American College of Obstetricians and Gynecologists, Technical Bulletin No. 56: Methods of Midtrimester Abortion (Dec. 1979).

The hospitalization requirement does not impose an undue burden, and it is not necessary to apply an exacting standard of review. Further, the regulation has a "rational relation" to a valid state objective of ensuring the health and welfare of its citizens. See *Williamson* v. *Lee Optical Co.*, 348 U. S. 483, 491 (1955).[11]

B

Section 1870.05(B) of the Akron ordinance provides that no physician shall perform an abortion on a minor under 15

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[11] The Court has never required that state regulation that burdens the abortion decision be "narrowly drawn" to express only the relevant state interest. In *Roe*, the Court mentioned "narrowly drawn" legislative enactments, 410 U. S., at 155, but the Court never actually adopted this standard in the *Roe* analysis. In its decision today, the Court fully endorses the *Roe* requirement that a burdensome health regulation, or as the Court appears to call it, a "significant obstacle," *ante*, at 16, be "reasonably related" to the state compelling interest. See *ante*, at 12, 17. The Court recognizes that "[a] State necessarily must have latitude in adopting regulations of general applicability in this sensitive area." *Id.*, at 16. See also *Simopoulos* v. *Virginia*, No. 81–185, *post*, at 10. Nevertheless, the Court fails to apply the "reasonably related" standard. The hospitalization requirement "reasonably relates" to its compelling interest in protection and preservation of maternal health under any normal understanding of what "reasonably relates" signifies.

The Court concludes that the regulation must fall because "it appears that during a substantial portion of the second trimester the State's regulation 'depart[s] from accepted medical practice,' *supra*, at 12." *Ante*, at 16. It is difficult to see how the Court concludes that the regulation "depart[s] from accepted medical practice" during "a substantial portion of the second trimester," *ante*, at 16, in light of the fact that the Court concludes that D&E abortions may be performed safely in an outpatient clinic through 16 weeks, or 4 weeks into the second trimester. *Ante*, at 18. Four weeks is hardly a "substantial portion" of the second trimester.

tional as applied to mature minors,[12] I see no reason to assume that the Akron ordinance and the state juvenile court statute compel state judges to notify the parents of a mature minor if such notification was contrary to the minor's best interests. Further, there is no reason to believe that the state courts would construe the consent requirement to impose any type of parental or judicial veto on the abortion decisions of mature minors. In light of the Court's complete lack of knowledge about how the Akron ordinance will operate, and how the Akron ordinance and the state juvenile court statute interact, our "'scrupulous regard for the rightful independence of state governments'" counsels against "unnecessary interference by the federal courts with proper and validly administered state concerns, a course so essential to the balanced working of our federal system." *Harrison* v. *NAACP*, *supra*, 360 U. S., at 176 (quoting *Matthews* v. *Rodgers*, 284 U. S. 521, 525 (1932)).

C

The Court invalidates the informed consent provisions of § 1870.06(B) and § 1870.06(C) of the Akron ordinance.[13] Al-

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[12] In my view, no decision of this Court has yet held that parental notification in the case of mature minors is unconstitutional. Although the plurality opinion of JUSTICE POWELL in *Bellotti II* suggested that the state statute in that case was unconstitutional because, *inter alia*, it failed to provide *all* minors with an opportunity "to go directly to a court without first consulting or notifying her parents," 443 U. S., at 647, the Court in *H.L.* v. *Matheson*, *supra*, held that *unemancipated and immature* minors had "no constitutional right to notify a court in lieu of notifying their parents." 450 U. S., at 412, n. 22. Furthermore, the Court in *H.L.* v. *Matheson* expressly did *not* decide that a parental notification requirement would be unconstitutional if the state otherwise permitted *mature* minors to make abortion decisions free of parental or judicial "veto." See *id.*, at 406–407.

[13] Section 1870.06(B) requires that the attending physician orally inform the pregnant woman: (1) that she is pregnant; (2) the probable number of weeks since conception; (3) that the unborn child is a human being from the

the state statute in the case required that the patient "be advised at a minimum about available adoption services, about fetal development, and about forseeable complications and risks of an abortion. See Utah Code Ann. § 76–7–305 (1978). In *Planned Parenthood of Central Mo.* v. *Danforth*, 428 U. S. 52, 65–67 (1976), we rejected a constitutional attack on written consent provisions." 450 U. S., at 400, n. 1. Indeed, we have held that an informed consent provision does not "unduly burden[] the right to seek an abortion." *Bellotti I, supra*, 428 U. S., at 147.[15]

The validity of subsections (3), (4), and (5) are not before the Court because it appears that the City of Akron conceded their unconstitutionality before the court below. See Brief for City of Akron in No. 79–3757 (CA6), at 35, Reply Brief for City of Akron in No. 79–3757, at 5–9. In my view, the remaining subsections of § 1870.06(B) are separable from the subsections conceded to be unconstitutional. Section 1870.19 contains a separability clause which creates a "'presumption of divisibility'" and places "the burden . . . on the litigant who would escape its operation." *Carter* v. *Carter Coal Co.*, 298 U. S. 238, 335 (1936) (Cardozo, J., dissenting in part and concurring in the judgment). Akron Center has failed to show that severence of subsections (3), (4), and (5) would "create a program quite different from the one the legislature actually adopted." *Sloan* v. *Lemon*, 413 U. S. 825, 834 (1973).

The remainder of § 1870.06(B), and § 1870.06(C), impose no undue burden or drastic limitation on the abortion decision.

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[15] Assuming *arguendo* that the Court now decides that *Danforth*, *supra*, *Bellotti II*, *supra*, and *H.L.* v. *Matheson* were incorrect, and that the informed consent provisions do burden the right to seek an abortion, the Court inexplicably refuses to determine whether this "burden" "reasonably relates" to legitimate state interests. *Ante*, at 12 (quoting *Roe*, *supra*, 410 U. S., at 163). Rather, the Court now decides that an informed-consent provision must be justified by a "vital state need" before it can be upheld. See *ante*, at 29.

651 F. 2d, at 1217 (Kennedy, J., concurring in part and dissenting in part). It is also interesting to note that the American College of Obstetricians and Gynecologists recommends that "[p]rior to abortion, the woman should have access to special counseling that explores options for the management of unwanted pregnancy, examines the risks, and allows sufficient time for reflection prior to making an informed decision." 1982 ACOG Standards for Obstetric-Gynecologic Services, at 54.

The waiting period does not apply in cases of medical emergency. Therefore, should the physician determine that the waiting period would increase risks significantly, he or she need not require the woman to wait. The Court's concern in this respect is simply misplaced. Although the waiting period may impose an additional cost on the abortion decision, this increased cost does not unduly burden the availability of abortions or impose an absolute obstacle to access to abortions. Further, the State is not required to "fine-tune" its abortion statutes so as to minimize the costs of abortions. *H.L.* v. *Matheson*, *supra*, 450 U. S., at 413.

Assuming *arguendo* that any additional costs are such as to impose an undue burden on the abortion decision, the State's compelling interests in maternal physical and mental health and protection of fetal life clearly justify the waiting period. As we acknowledged in *Danforth*, *supra*, 428 U. S., at 67, the decision to abort is "a stressful one," and the waiting period reasonably relates to the State's interest in ensuring that a woman does not make this serious decision in undue haste. The decision also has grave consequences for the fetus, whose life the State has a compelling interest to protect and preserve. "No other [medical] procedure involves the purposeful termination of a potential life." *Harris*, *supra*, 448 U. S., at 325. The waiting period is surely a small cost to impose to ensure that the woman's decision is well-considered in light of its certain and irreparable consequences on fetal life, and the possible effects on her own.[17]

[17] On the basis of this analysis of the waiting-period requirement, the

V

For the reasons set forth above, I dissent from the judgment of the Court in these cases.

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SUPREME COURT OF THE UNITED STATES

Nos. 81–1255 AND 81–1623

PLANNED PARENTHOOD ASSOCIATION OF KANSAS CITY, MISSOURI, INC., ET AL., PETITIONERS

81–1255 *v.*

JOHN ASHCROFT, ATTORNEY GENERAL OF MISSOURI, ET AL.

JOHN ASHCROFT, ATTORNEY GENERAL OF MISSOURI, ET AL., PETITIONERS

81–1623 *v.*

PLANNED PARENTHOOD ASSOCIATION OF KANSAS CITY, MISSOURI, INC., ET AL., PETITIONERS

ON WRITS OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

[June 15, 1983]

JUSTICE POWELL delivered the opinion of the Court with respect to Parts I, II, and VI, and an opinioin with respect to Parts III, IV, and V, in which THE CHIEF JUSTICE joins.

These cases, like *City of Akron* v. *Akron Center for Reproductive Health, Inc.*, *ante*, p. ——, and *Simopoulos* v. *Virginia*, *post*, p. ——, present questions as to the validity of state statutes regulating the performance of abortions.

I

Planned Parenthood of Kansas City, Missouri, Inc., two physicians who perform abortions, and an abortion clinic

("plaintiffs") filed a complaint in the District Court for the Western District of Missouri challenging, as unconstitutional, several sections of the Missouri statutes regulating the performance of abortions. The sections relevant here include Mo. Rev. Stat. § 188.025 (Supp. 1982), requiring that abortions after 12 weeks of pregnancy be performed in a hospital;[1] § 188.047, requiring a pathology report for each abortion performed;[2] § 188.030, requiring the presence of a second physician during abortions performed after viability;[3] and § 188.028, requiring minors to secure parental or judicial consent.[4]

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[1] Mo. Rev. Stat. § 188.025 provides: "Every abortion performed subsequent to the first twelve weeks of pregnancy shall be performed in a hospital."

[2] Mo. Rev. Stat. § 188.047 provides:

"A representative sample of tissue removed at the time of abortion shall be submitted to a board eligible or certified pathologist, who shall file a copy of the tissue report with the state division of health, and who shall provide a copy of the report to the abortion facility or hospital in which the abortion was performed or induced and the pathologist's report shall be made a part of the patient's permanent record."

[3] Mo. Rev. Stat. § 188.030.3 provides:

"An abortion of a viable unborn child shall be performed or induced only when there is in attendance a physician other than the physician performing or adducing the abortion who shall take control of and provide immediate medical care for a child born as a result of the abortion. During the performance of the abortion, the physician performing it, and subsequent to the abortion, the physician required by this section to be in attendance, shall take all reasonable steps in keeping with good medical practice, consistent with the procedure used, to preserve the life and health of the viable unborn child; provided that it does not pose an increased risk to the life or health of the woman."

[4] Mo. Rev. Stat. § 188.028 provides:

"1. No person shall knowingly perform an abortion upon a pregnant woman under the age of eighteen years unless:

"(1) The attending physician has secured the informed written consent of the minor and one parent or guardian: or

"(2) The minor is emancipated and the attending physician has received the informed written consent of the minor; or

After hearing testimony from a number of expert witnesses, the District Court invalidated all of these sections except the pathology requirement. 483 F. Supp. 679, 699–701 (1980).[5] The Court of Appeals for the Eighth Circuit re-

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"(3) The minor has been granted the right to self-consent to the abortion by court order pursuant to subsection 2 of this section, and the attending physician has received the informed written consent of the minor; or

"(4) The minor has been granted consent to the abortion by court order, and the court has given its informed written consent in accordance with subsection 2 of this section, and the minor is having the abortion willingly, in compliance with subsection 3 of this section.

"2. The right of a minor to self-consent to an abortion under subdivision (3) of subsection 1 of this section or court consent under subdivision (4) of subsection 1 of this section may be granted by a court pursuant to the following procedures:

"(1) The minor or next friend shall make an application to the juvenile court which shall assist the minor or next friend in preparing the petition and notices required pursuant to this section. The minor or the next friend of the minor shall thereafter file a petition setting forth the initials of the minor; the age of the minor; the names and addresses of each parent, guardian, or, if the minor's parents are deceased and no guardian has been appointed, any other person standing in loco parentis of the minor; that the minor has been fully informed of the risks and consequences of the abortion; that the minor is of sound mind and has sufficient intellectual capacity to consent to the abortion; that, if the court does not grant the minor majority rights for the purpose of consent to the abortion, the court should find that the abortion is in the best interest of the minor and give judicial consent to the abortion; that the court should appoint a guardian ad litem of the child; and if the minor does not have private counsel, that the court should appoint counsel. The petition shall be signed by the minor or the next friend;

. . . . .

"(3) A hearing on the merits of the petition, to be held on the record, shall be held as soon as possible within five days of the filing of the petition. . . . At the hearing, the court shall hear evidence relating to the emotional development, maturity, intellect and understanding of the minor; the nature, possible consequences, and alternatives to the abortion; and any other evidence that the court may find useful in determining whether the minor should be granted majority rights for the purpose of consenting to

[Footnote 5 is on page 4]

versed the District Court's judgment with respect to § 188.028, thereby upholding the requirement that a minor secure parental or judicial consent to an abortion. It also held that the District Court erred in sustaining § 188.047, the pathology requirement. The District Court's judgment with respect to the second-physician requirement was affirmed, and the case was remanded for further proceedings and findings relating to the second-trimester hospitalization requirement. 655 F. 2d 848, 872–873 (1981). On remand, the District Court affirmed its holding that the second-trimester hospitalization requirement was unconstitutional. The Court of Appeals affirmed this judgment. 664 F. 2d 687, 691 (1981). We granted certiorari. 456 U. S. 988 (1982).

The Court today in *City of Akron*, *ante*, at 8–12, has stated fully the principles that govern judicial review of state statutes regulating abortions, and these need not be repeated

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the abortion or whether the abortion is in the best interests of the minor;

"(4) In the decree, the court shall for good cause:

"(a) Grant the petition for majority rights for the purpose of consenting to the abortion; or

"(b) Find the abortion to be in the best interests of the minor and give judicial consent to the abortion, setting forth the grounds for so finding; or

"(c) Deny the petition, setting forth the grounds on which the petition is denied;

"3. If a minor desires an abortion, then she shall be orally informed of and, if possible, sign the written consent required by section 188.039 in the same manner as an adult person. No abortion shall be performed on any minor against her will, except that an abortion may be performed against the will of a minor pursuant to a court order described in subdivision (4) of subsection 1 of this section that the abortion is necessary to preserve the life of the minor."

[3]The District Court also awarded attorney's fees for all hours claimed by the plaintiffs' attorneys. The Court of Appeals affirmed this allocation of fees. See 655 F. 2d 848, 872 (CA8 1981). The petition for certiorari raises the issue whether an award of attorney's fees, made pursuant to 42 U. S. C. § 1988, should be proportioned to reflect the extent to which plaintiffs prevailed.

here. With these principles in mind, we turn to the statutes at issue.

II

In *City of Akron*, we invalidated a city ordinance requiring physicians to perform all second-trimester abortions at general or special hospitals accredited by the Joint Commission on Accreditation of Hospitals (JCAH) or by the American Osteopathic Association. *Ante*, at 13. Missouri's hospitalization requirements are similar to those enacted by Akron, as all second-trimester abortions must be performed in general, acute-care facilities.[6] For the reasons stated in *City of Akron*, we held that such a requirement "unreasonably infringes upon a woman's constitutional right to obtain an abortion." *Ante*, at 20–21. For the same reasons, we af-

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[6] Missouri does not define the term "hospital" in its statutory provisions regulating abortions. We therefore must assume, as did the courts below, see 483 F. Supp., at 686, n. 10; 664 F. 2d, at 689–690, and nn. 3, 5 and 6, that the term has its common meaning of a general, acute-care facility. Cf. Mo. Rev. Stat. § 188.015(2) (Supp. 1982) (defining "abortion facility" as "a clinic, physician's office, or any other place or facility in which abortions are performed other than a hospital"). Section 197.020.2 (1978), part of Missouri's hospital licensing laws, reads:

"'**Hospital**' means a place devoted primarily to the maintenance and operation of facilities for the diagnosis, treatment or care for not less than twenty-four hours in any week of three or more nonrelated individuals suffering from illness, disease, injury, deformity or other abnormal physical conditions; or a place devoted primarily to provide for not less than twenty-four hours in any week medical . . . care for three or more nonrelated individuals. . . ."

Cf. Mo. Rev. Stat. § 197.200(1) (1978) (defining "ambulatory surgical center" to include facilities "with an organized medical staff of physicians" and "with continuous physician services and registered professional nursing services whenever a patient is in the facility"); 13 Mo. Admin. Code 50–30.010(1)(A) (1977) (same). The regulations for the Department of Social Services establish standards for the construction, physical facilities, and administration of hospitals. *Id.*, 50–20.010 to 50–20.030 (1977). These are not unlike those set by JCAH. See *City of Akron*, *ante*, at 13, and n. 16.

firm the Court of Appeals' judgment that § 188.025 is unconstitutional.

III

We turn now to the State's second-physician requirement. In *Roe* v. *Wade*, 410 U. S. 113 (1973), the Court recognized that the State has a compelling interest in the life of a viable fetus: "[T]he State in promoting its interest in the potentiality of human life may, if it chooses, regulate, and even proscribe, abortion except where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother." *Id.*, at 164–165. See *Colautti* v. *Franklin*, 439 U. S. 379, 386–387 (1979); *Beal* v. *Doe*, 432 U. S. 438, 445–446 (1977). Several of the Missouri statutes undertake such regulation. Post-viability abortions are proscribed except when necessary to preserve the life or the health of the woman. Mo. Rev. Stat. § 188.030.1 (Supp. 1982). The State also forbids the use of abortion procedures fatal to the viable fetus unless alternative procedures pose a greater risk to the health of the woman. § 188.030.2.

The statutory provision at issue in this case requires the attendance of a second physician at the abortion of a viable fetus. § 188.030.3. This section requires that the second physician "take all reasonable steps in keeping with good medical practice . . . to preserve the life and health of the viable unborn child; provided that it does not pose an increased risk to the life or health of the woman." See n. 3, *supra*. It also provides that the second physician "shall take control of and provide immediate medical care for a child born as a result of the abortion."

The lower courts invalidated § 188.030.3.[7] The plaintiffs, respondents here on this issue, urge affirmance on the

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[7]The courts below found, and JUSTICE BLACKMUN's dissenting opinion agrees, *post*, at 6–7, that there is no possible justification for a second-physician requirement whenever D&E is used because no viable fetus can survive a D&E procedure. 483 F. Supp., at 694; 655 F. 2d, at 865. Accord-

grounds that the second-physician requirement distorts the traditional doctor-patient relationship, and is both impractical and costly. They note that Missouri does not require two physicians in attendance for any other medical or surgical procedure, including childbirth or delivery of a premature infant.

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ingly, for them, § 188.030.3 is overbroad. This reasoning rests on two assumptions. First, a fetus cannot survive a D&E abortion, and second, D&E is the method of choice in the third trimester. There is general agreement as to the first proposition, but not as to the second. Indeed, almost all of the authorities disagree with JUSTICE BLACKMUN's critical assumption, and as the Court of Appeals noted, the choice of this procedure after viability is subject to the requirements of § 188.030.2. See *id.*, at 865, and n. 28. Nevertheless, the courts below, in conclusory language, found that D&E is the "method of choice even after viability is possible." 655 F. 2d, at 865. No scholarly writing supporting this view is cited by those courts or by the dissent. Reliance apparently is placed solely on the testimony of Dr. Robert Crist, a physician from Kansas, to whom the District Court referred in a footnote. 483 F. Supp., at 694, n. 25. This testimony provides slim support for this holding. Dr. Crist's testimony, if nothing else, is remarkable in its candor. He is a member of the National Abortion Federation, "an organization of abortion providers and people interested in the pro-choice movement." 2 Record 415–416. He supported the use of D&E on 28-week pregnancies, well into the third trimester. In some circumstances, he considered it a better procedure than other methods. See 2 Record 427–428. His disinterest in protecting fetal life is evidenced by his agreement "that the abortion patient has a right not only to be rid of the growth, called a fetus in her body, but also has a right to a dead fetus." *Id.*, at 431. He also agreed that he "[n]ever ha[s] any intention of trying to protect the fetus, if it can be saved," *id.*, and finally that "as a general principle" "[t]here should not be a live fetus," *id.*, at 435. Moreover, contrary to every other view, he thought a fetus could survive a D&E abortion. *Id.*, at 433–434. None of the other physicians who testified at the trial, those called both by the plaintiffs and defendants, considered that *any* use of D&E after viability was indicated. See 1 Record 21 (limiting use of D&E to under 18 weeks); 2 Record 381, 410–413 (Dr. Robert Kretzschmar) (D&E up to 17 weeks: would never perform D&E after 26 weeks); 4 Record 787 (almost "inconceivable" to use D&E after viability); 7 Record 52 (D&E safest up to 18 weeks); *id.*, at 110 (doctor not performing D&E past 20 weeks); *id.*, at 111 (risks of doing outpatient D&E

The first physician's primary concern will be the life and health of the woman. Many third-trimester abortions in Missouri will be emergency operations,[8] as the State permits these late abortions only when they are necessary to preserve the life or the health of the woman. It is not unreason-

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equivalent to childbirth at 24 weeks). See also 8 Record 33, 78–81 (deposition of Dr. Willard Cates) (16 weeks latest D&E performed). Apparently Dr. Crist performed abortions only in Kansas, 2 Record 334, 368, 428, a state having no statutes comparable to § 188.030.1 and § 188.030.2. It is not clear whether he was operating under or familiar with the limitations imposed by Missouri law. Nor did he explain the circumstances when there were "contraindications" against the use of any of the procedures that could preserve viability, or whether his conclusory opinion was limited to emergency situations. Indeed, there is no record evidence that D&E ever will be the method that poses the least risk to the woman in those rare situations where there are compelling medical reasons for performing an abortion after viability. If there were such instances, they hardly would justify invalidating § 188.030.3.

In addition to citing Dr. Crist in its footnote, the District Court cited—with no elaboration—Dr. Schmidt. His testimony, reflecting no agreement with Dr. Crist, is enlightening. Although he conceded that the attendance of a second physician for a D&E abortion on a viable fetus was not necessary, he considered the point mostly theoretical, because he "simply [did] not believe that the question of viability comes up when D&E is an elected method of abortion." 4 Record 836. When reminded of Dr. Crist's earlier testimony, he conceded the remote possibility of third-trimester D&E abortions, but stated: "I personally cannot conceive that as a significant practical point. It may be important legally, but [not] from a medical standpoint. . . ." *Ibid.* Given that Dr. Crist's discordant testimony is wholly unsupported, the State's compelling interest in protecting a viable fetus justifies the second-physician requirement even though there may be the rare case when a physician may think honestly that D&E is required for the mother's health. Legislation need not accommodate every conceivable contingency.

[8]There is no clearly expressed exception on the face of the statute for the performance of an abortion of a viable fetus without the second physician in attendance. There may be emergency situations where, for example, the woman's health may be endangered by delay. Section § 188.030.3 is qualified, at least in part, by the phrase "provided that it does not pose an increased risk to the life or health of the woman." This clause reasonably could be construed to apply to such a situation. Cf. *H.L.* v. *Math-*

able for the State to assume that during the operation the first physician's attention and skills will be directed to preserving the woman's health, and not to protecting the actual life of those fetuses who survive the abortion procedure. Viable fetuses will be in immediate and grave danger because of their premature birth. A second physician, in situations where Missouri permits third-trimester abortions, may be of assistance to the woman's physician in preserving the health and life of the child.

By giving immediate medical attention to a fetus that is delivered alive, the second physician will assure that the State's interests are protected more fully than the first physician alone would be able to do. And given the compelling interest that the State has in preserving life, we cannot say that the Missouri requirement of a second physician in those unusual circumstances where Missouri permits a third-trimester abortion is unconstitutional. Preserving the life of a viable fetus that is aborted may not often be possible,[9] but the State legitimately may choose to provide safeguards for the comparatively few instances of live birth that occur. We believe the second-physician requirement reasonably furthers the State's compelling interest in protecting the lives of viable fetuses, and we reverse the judgment of the Court of Appeals holding that § 188.030.3 is unconstitutional.

IV

In regulating hospital services within the State, Missouri

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eson, 450 U. S. 398, 407, n. 14 (1981) (rejecting argument that Utah statute might apply to individuals with emergency health care needs).

[9] See ACOG Technical Bulletin No. 56, *supra* n. 7, at 4 (as high as 7% live-birth rate for intrauterine instillation of uterotonic agents); Stroh & Hinman, Reported Live Births Following Induced Abortion: Two and One-Half Years' Experience in Upstate New York, 126 Am. J. Obstet. Gynecol. 83, 83–84 (1976) (26 live births following saline induced-abortions: 9 following hysterotomy; 1 following oxtyocin-induced abortion) (one survival out of 38 live births); 4 Record 728 (50–62% mortality rate for fetuses 26 and 27 weeks); *id.*, at 729 (25–92% mortality rate for fetuses 28 and 29 weeks); *id.*, at 837 (50% mortality rate at 34 weeks).

requires that "[a]ll tissue surgically removed with the exception of such tissue as tonsils, adenoids, hernial sacs and prepuces, shall be examined by a pathologist, either on the premises or by arrangement outside of the hospital." 13 Mo. Admin. Code 50–20.030(3)(A)7 (1977). With respect to abortions, whether performed in hospitals or in some other facility, § 188.047 requires the pathologist to "file a copy of the tissue report with the State Division of Health. . . ." See n. 2, *supra*. The pathologist also is required to "provide a copy of the report to the abortion facility or hospital in which the abortion was performed or induced." Thus, Missouri appears to require that tissue following abortions, as well as from almost all other surgery performed in hospitals, must be submitted to a pathologist, not merely examined by the performing doctor. The narrow question before us is whether the State lawfully also may require the tissue removed following abortions performed in clinics as well as in hospitals to be submitted to a pathologist.

On its face and in effect, § 188.047 is reasonably related to generally accepted medical standards and "further[s] important health-related State concerns." *City of Akron*, *ante*, at 12. As the Court of Appeals recognized, pathology examinations are clearly "useful and even necessary in some cases," because "abnormalities in the tissue may warn of serious, possibly fatal disorders." 655 F. 2d, at 870.[10] As a rule, it is

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[10] A pathological examination is designed to assist in the detection of fatal ectopic pregnancies, hydatritaforme moles or other precancerous growths, and a variety of other problems that can be discovered only through a pathological examination. The general medical utility of pathological examinations is clear. See, *e. g.*, American College of Obstetricians and Gynecologists (ACOG), Standards for Obstetric-Gynecologic Services 52 (5th ed. 1982); National Abortion Federation (NAF), National Abortion Federation Standards 6 (1981) (compliance with standards obligatory for NAF member facilities to remain in good standing); Brief of the American Public Health Association as *Amicus Curiae* in Nos. 81–185.

accepted medical practice to submit *all* tissue to the examination of a pathologist.[11] This is particularly important following abortion, because questions remain as to the long-range complications and their effect on subsequent pregnancies. See App. 72–73 (testimony of Dr. Willard Cates, Jr.); Levin, et al., Association of Induced Abortion with Subsequent Pregnancy Loss, 243 J. A.M.A. 2495, 2499 (1980). Recorded pathology reports, in concert with abortion complication reports, provide a statistical basis for studying those complications. Cf. *Planned Parenthood of Central Mo.* v. *Danforth*, 428 U. S. 52, 81 (1976).

Plaintiffs argue that the physician performing the abortion is as qualified as a pathologist to make the examination. This argument disregards the fact that Missouri requires a pathologist—not the performing physician—to examine tissue after almost every type of surgery. Although this requirement is in a provision relating to surgical procedures in hospitals, many of the same procedures included within the

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81–746, 81–1172, at 29, n. 6 (supporting the NAF standards for non-hospital abortion facilities as constituting "minimum standards").

[11] ACOG's standards at the time of the District Court's trial recommended that a "tissue or operative review committee" should examine "all tissue removed at obstetric-gynecologic operations." ACOG, Standards for Obstetric-Gynecologic Services 13 (4th ed. 1974). The current ACOG standards also state as a general rule that, for all surgical services performed on an ambulatory basis, "[t]issue removed should be submitted to a pathologist for an examination." ACOG, *supra*, at 52 (5th ed. 1982). The dissent, however, relies on the recent modification of these standards as they apply to abortions. ACOG now provides an "exception to the practice" of mandatory examination by a pathologist and makes such examination for abortion tissue permissive. *Ibid.* Not surprisingly, this change in policy was controversial within the College. See 4 Record 799–800. ACOG found that "[n]o consensus exists regarding routine microscopic examination of aspirated tissue in every case," though it recognized—on the basis of inquiries made in 29 institutions—that in a majority of them a microscopic examination is performed in all cases. ACOG, Report of Committee on Gynecologic Practice, Item #6.2.1 (June 27–28, 1980).

Missouri statute customarily are performed also in outpatient clinics. No reason has been suggested why the prudence required in a hospital should not be equally appropriate in such a clinic. Indeed, there may be good reason to impose stricter standards in this respect on clinics performing abortions than on hospitals.[12] As the testimony in the District Court indicates, medical opinion differs widely on this question. See 3 Record 623; 4 Record 749–750, 798–800, 845–847; n. 2, *supra*. There is substantial support for Missouri's requirement. In this case, for example, Dr. Bernard Nathanson, a widely experienced abortion practitioner, testified that he requires a pathologist examination after each of the 60,000 abortions performed under his direction at the New York Center for Reproductive and Sexual Health. He considers it "absolutely necessary to obtain a pathologist's report on each and every specimen of tissue removed for abortion or for that matter from any other surgical procedure which involved the removal of tissue from the human body."

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[12] The professional views that the plaintiffs find to support their position do not disclose whether consideration was given to the fact that not all abortion clinics, particularly inadequately regulated clinics, conform to ethical or generally accepted medical standards. See *Bellotti* v. *Baird*, 443 U. S. 622, 641, n. 21 (1979) (*Bellotti II*) (minors may resort to "incompetent or unethical" abortion clinics); *Planned Parenthood of Central Mo.* v. *Danforth*, 428 U. S. 52, 91, n. 2 (1976) (Stewart, J., concurring). The Sun-Times of Chicago, in a series of special reports, disclosed widespread questionable practices in abortion clinics in Chicago, including the failure to obtain proper pathology reports. See "The Abortion Profiteers," Chicago Sun-Times 25–26 (Special Reprint 1978). It is clear, therefore, that a State reasonably could conclude that a pathology requirement is necessary in abortion clinics as well as in general hospitals.

In suggesting that we make from a "comfortable perspective" the judgment that a State constitutionally can require the additional cost of a pathology examination, the dissent suggests that we disregard the interests of the "woman on welfare or the unemployed teenager." *Post*, at 4. But these women may be those most likely to seek the least expensive clinic available. As the standards of medical practice in such clinics may not be the highest, a State may conclude reasonably that a pathologist's examination of tissue is particularly important for their protection.

App. 143–144. See also App. 146–147 (testimony of Dr. Keitges); 5 Record 798–799 (testimony of Dr. Schmidt).[13]

In weighing the balance between protection of a woman's health and the comparatively small additional cost of a pathologist's examination, we cannot say that the Constitution requires that a State subordinate its interest in health to minimize to this extent the cost of abortions. Even in the early weeks of pregnancy, "[c]ertain regulations that have no significant impact on the woman's exercise of her right to decide to have an abortion may be permissible where justified by important state health objectives." *City of Akron*, *ante*, at 11. See *Danforth*, 428 U. S., at 80–81. We think the cost of a tissue examination does not significantly burden a pregnant woman's abortion decision. The estimated cost of compliance for plaintiff Reproductive Health Services was $19.40 per abortion performed, 483 F. Supp., at 700, n. 48, and in light of the substantial benefit's that a pathologist's examination can have, this small cost clearly is justified. In *Danforth*, this Court unanimously upheld Missouri's recordkeeping requirement as "useful to the State's interest in protecting the health of its female citizens, and [as] a resource that is relevant to decisions involving medical experience and judgment," 428 U. S., at 81.[14] We view the re-

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[13] The dissent appears to suggest that § 188.047 is constitutionally infirm because it does not require microscopic examination, *post*, at 4, but that misses the point of the regulation. The need is for someone other than the performing clinic to make an independent medical judgment on the tissue. See n. 12, *supra*; 4 Record 750 (Dr. Pierre Keitges, a pathologist). It is reasonable for the State to assume that an independent pathologist is more likely to perform a microscopic examination than the performing doctor. See H. Cove, Surgical Pathology of the Endometrium 28 (1981) ("To the pathologist, abortions of any sort are evaluated grossly *and* microscopically for the primary purpose of establishing a diagnosis of intrauterine pregnancy.") (emphasis added).

[14] The *Danforth* Court also noted that "[t]he added requirements for confidentiality, with the sole exception for public health officers, and for retention for seven years, a period not unreasonable in length, assist and persuade us in our determination of the constitutional limits." 428 U. S.,

quirement for a pathology report as comparable and as a relatively insignificant burden. Accordingly, we reverse the judgment of the Court of Appeals on this issue.

V

As we noted in *City of Akron*, the relevant legal standards with respect to parental consent requirements are not in dispute. See *ante*, at 21; *Bellotti* v. *Baird*, 443 U. S. 622, 640–642, 643–644 (1979) (plurality opinion) *(Bellotti II)*; *id.*, at 656–657 (WHITE, J., dissenting).[15] A State's interest in protecting immature minors will sustain a requirement of a consent substitute, either parental or judicial. It is clear, however, that "the State must provide an alternative procedure whereby a pregnant minor may demonstrate that she is sufficiently mature to make the abortion decision herself or that, despite her immaturity, an abortion would be in her best interests."[16] *City of Akron*, *ante*, at 21–22.[17] The issue

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at 81. Missouri extends the identical safeguards found reassuring in *Danforth* to the pathology reports at issue here. See Mo. Rev. Stat. §§ 188.055.2, 188.060 (Supp. 1982).

[15] The dissenters apparently believe that the issue here is an open one, and adhere to the views they expressed in *Bellotti II*. *Post*, at 10–11. But those views have never been adopted by a majority of this Court, while a majority have expressed quite differing views. See *H.L.* v. *Matheson*, 450 U. S. 398 (1981); *Bellotti II*, 443 U. S. 622 (plurality opinion); *id.*, at 656–657 (WHITE, J., dissenting).

[16] The plurality in *Bellotti II* also required that the alternative to parental consent must "assure" that the resolution of this issue "will be completed with anonymity and sufficient expedition to provide an effective opportunity for an abortion to be obtained." *Id.*, at 644. Confidentiality here is assured by the statutory requirement that allows the minor to use her initials on the petition. Mo. Rev. Stat. § 188.028.2(1) (Supp. 1982). As to expedition of appeals, § 188.028.2(6) provides in relevant part:

"The notice of intent to appeal shall be given within twenty-four hours from the date of issuance of the order. The record on appeal shall be completed and the appeal shall be perfected within five days from the filing of notice to appeal. Because time may be of the essence regarding the performance of the abortion, the supreme court of this state shall, by court rule, provide

here is one purely of statutory construction: whether Missouri provides a judicial alternative that is consistent with these established legal standards.[18]

The Missouri statute, § 188.028.2,[19] in relevant part, provides:

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for expedited appellate review of cases appealed under this section."

We believe this section provides the framework for a constitutionally sufficient means of expediting judicial proceedings. Immediately after the effective date of this statutory enactment, the District Court enjoined enforcement. No unemancipated pregnant minor has been required to comply with this section. Thus, to this point in time, there has been no need for the state supreme court to promulgate rules concerning appellate review. There is no reason to believe that Missouri will not expedite any appeal consistent with the mandate in our prior opinions.

[17] Cf. *H.L.* v. *Matheson*, 450 U. S., at 406–407, and n. 14, 411 (upholding a parental notification requirement but not extending the holding to mature or emancipated minors or to immature minors showing such notification detrimental to their best interests). The lower courts found that § 188.028's notice requirement was unconstitutional. 655 F. 2d, at 873; 483 F. Supp., at 701. The State has not sought review of that judgment here. Thus, in the posture in which it appears before this Court for review, § 188.028 contains no requirement for parental notification.

[18] The Missouri statute also exempts "emancipated" women under the age of 18 both from the requirement of parental consent and from the alternative requirement of a judicial proceeding. Plaintiffs argue that the word "emancipated" in this context is void for vagueness, but we disagree. Cf. *H.L.* v. *Matheson*, *supra*, at 407 (using word to describe a minor). Although the question whether a minor is emancipated turns upon the facts and circumstances of each individual case, the Missouri courts have adopted general rules to guide that determination, and the term is one of general usage and understanding in the Missouri common law. See *Black* v. *Cole*, 626 S. W. 2d 397, 398 (Mo. App. 1981) (quoting 67 C. J. S. Parent and Child § 86, at 811 (1950)); *In re the Marriage of Heddy*, 535 S. W. 2d 276, 279 (Mo. App. 1976) (same); *Wurth* v. *Wurth*, 313 S. W. 2d 161, 164 (Mo. App. 1958) (same), rev'd on other grounds, 322 S. W. 2d 745 (Mo. 1959).

[19] See n. 4, *supra*. This Court in *Danforth* held unconstitutional Missouri's parental consent requirement for all unmarried minors under the age of 18. 428 U. S., at 75. In response to our decision, Missouri enacted the section challenged here. This new statute became effective shortly before our decision in *Bellotti II*.

"(4) In the decree, the court shall for good cause:

"(a) Grant the petition for majority rights for the purpose of consenting to the abortion; or

"(b) Find the abortion to be in the best interests of the minor and give judicial consent to the abortion, setting forth the grounds for so finding; or

"(c) Deny the petition, setting forth the grounds on which the petition is denied[.]"

On its face, § 188.028.2(4) authorizes juvenile courts[20] to choose among any of the alternatives outlined in the section. The Court of Appeals concluded that a denial of the petition permitted in subsection (c) "would initially require the court to find that the minor was not emancipated and was not mature enough to make her own decision and that an abortion was not in her best interests." 655 F. 2d, at 858. Plaintiffs contend that this interpretation is unreasonable. We do not agree.

Where fairly possible, courts should construe a statute to avoid a danger of unconstitutionality. The Court of Appeals was aware, if the statute provides discretion to deny permission to a minor for *any* "good cause," that arguably it would violate the principles that this Court has set forth. *Ibid.* It recognized, however, that before exercising any option, the juvenile court must receive evidence on "the emotional development, maturity, intellect and understanding of the minor." Mo. Rev. Stat. § 188.028.2(3) (Supp. 1982). The court then reached the logical conclusion that "findings and the ultimate denial of the petition must be supported by a showing of 'good cause.'" 655 F. 2d, at 858. The Court of Appeals reason-

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[20] We have indicated in prior opinions that a minor should have access to an "independent decisionmaker." *H.L. v. Matheson*, *supra*, at 420 (POWELL, J., concurring). Missouri has provided for a judicial decisionmaker. We therefore need not consider whether a qualified and independent nonjudicial decisionmaker would be appropriate. *Cf. Bellotti II*, 443 U.S., at 643, n. 22.

ably found that a court could not deny a petition "for good cause" unless it first found—after having received the required evidence—that the minor was not mature enough to make her own decision. See *Bellotti II*, 443 U. S., at 643–644, 647–648 (plurality opinion). We conclude that the Court of Appeals correctly interpreted the statute and that § 188.028, as interpreted, avoids any constitutional infirmities.[21]

VI

The judgment of the Court of Appeals, insofar as it invalidated Missouri's second-trimester hospitalization requirement and upheld the State's parental and juducial consent provision, is affirmed. The judgment invalidating the requirement of a pathology report for all abortions and the requirement that a second physician attend the abortion of any viable fetus is reversed. We vacate the judgment upholding an award of attorney's fees for all hours expended by plaintiffs' attorneys and remand for proceedings consistent with *Hensley* v. *Eckerhart*, —— U. S. —— (1983).

It is so ordered.

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[21] Plaintiffs also argue that, in light of the ambiguity of § 188.028.2(4), as evidenced by the differing interpretations placed upon it, the appropriate course of judicial restraint is abstention. This Court has found such an approach appropriate. See *Bellotti* v. *Baird*, 428 U. S. 132, 146–147 (1976) (*Bellotti I*). Plaintiffs did not, however, argue in the Court of Appeals that the court should abstain, and Missouri has no certification procedure whereby this Court can refer questions of state statutory construction to the state supreme court. See 655 F. 2d, at 861, n. 20; 17 C. Wright, A. Miller & E. Cooper, Federal Practice and Procedure § 4248, at 525, n. 29 (1978 and Supp. 1982). Such a procedure "greatly simplifie[d]" our analysis in *Bellotti I*, *supra*, at 151. Moreover, where, as here, a statute is susceptible to a fair construction that obviates the need to have the state courts render the saving construction, there is no reason for federal courts to abstain.

SUPREME COURT OF THE UNITED STATES

Nos. 81–1255 AND 81–1623

PLANNED PARENTHOOD ASSOCIATION OF KANSAS CITY, MISSOURI, INC., ET AL., PETITIONERS

81–1255 *v.*

JOHN ASHCROFT, ATTORNEY GENERAL OF MISSOURI, ET AL.

JOHN ASHCROFT, ATTORNEY GENERAL OF MISSOURI, ET AL., PETITIONERS

81–1623 *v.*

PLANNED PARENTHOOD ASSOCIATION OF KANSAS CITY, MISSOURI, INC., ET AL., PETITIONERS

ON WRITS OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

[June 15, 1983]

JUSTICE O'CONNOR, with whom JUSTICE WHITE and JUSTICE REHNQUIST join, concurring in part in the judgment and dissenting in part.

For reasons stated in my dissent in No. 81–746, *Akron* v. *Akron Center for Reproductive Health* and in No. 81–1172, *Akron Center for Reproductive Health* v. *Akron*, I believe that the second-trimester hospitalization requirement imposed by § 188.025 does not impose an undue burden on the limited right to undergo an abortion. Assuming *arguendo* that the requirement was an undue burden, it would nevertheless "reasonably relate[] to the preservation and protec-

tion of maternal health." *Roe* v. *Wade*, 410 U. S. 113 , 163 (1973). I therefore dissent from the Court's judgment that the requirement is unconstitutional.

I agree that second-physician requirement contained in § 188.030.3 is constitutional because the State possesses a compelling interest in protecting and preserving fetal life, but I believe that this state interest is extant throughout pregnancy. I therefore concur in the judgment of the Court.

I agree that pathology-report requirement imposed by § 188.047 is constitutional because it imposes no undue burden on the limited right to undergo an abortion. Because I do not believe that the validity of this requirement is contingent in any way on the trimester of pregnancy in which it is imposed, I concur in the judgment of the Court.

Assuming *arguendo* that the State cannot impose a parental veto on the decision of a minor to undergo an abortion, I agree that the parental consent provision contained in § 188.028.2 is constitutional. However, I believe that the provision is valid because it imposes no undue burden on any right that a minor may have to undergo an abortion. I concur in the judgment of the Court on this issue.

I also concur in the Court's decision to vacate and remand on the issue of attorney's fees in light of *Hensley* v. *Eckerhart*, —— U. S. —— (1983).

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ON WRITS OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

[June 15, 1983]

JUSTICE BLACKMUN, with whom JUSTICE BRENNAN, JUSTICE MARSHALL, and JUSTICE STEVENS join, concurring in part and dissenting in part.

The Court's decision today in *Akron* v. *Akron Center for Reproductive Health, Inc.*, *ante*, invalidates the city of Akron's hospitalization requirement and a host of other provisions that infringe on a woman's decision to terminate her pregnancy through abortion. I agree that Missouri's hospitalization requirement is invalid under the *Akron* analysis, and I join Parts I and II of JUSTICE POWELL'S opinion in the present cases. I do not agree, however, that the remaining

Missouri statutes challenged in these cases satisfy the constitutional standards set forth in *Akron* and the Court's prior decisions.

I

Missouri law provides that whenever an abortion is performed, a tissue sample must be submitted to a "board eligible or certified pathologist" for a report. Mo. Rev. Stat. § 188.047 (1983). This requirement applies to first trimester abortions as well as to those performed later in pregnancy. Our past decisions establish that the performance of abortions during the first trimester must be left "'free of interference by the State.'" *Akron*, *ante*, at 12, quoting *Roe* v. *Wade*, 410 U. S. 113, 163 (1973). As we have noted in *Akron*, this does not mean that every regulation touching upon first-trimester abortions is constitutionally impermissible. But to pass constitutional muster, regulations affecting first-trimester abortions must "have no significant impact on the woman's exercise of her right" and must be "justified by important state health objectives." *Akron*, *ante*, at 11; see *ante*, at 13.

Missouri's requirement of a pathologist's report is not justified by important health objectives. Although pathology examinations may be "useful and even necessary in some cases," *ante*, at 10, Missouri requires more than a pathology examination and a pathology report; it demands that the examination be performed and the report prepared by a "board eligible or certified pathologist" rather than by the attending physician. Contrary to JUSTICE POWELL'S assertion, *ante*, at 10, this requirement of a report by a pathologist is not in accord with "generally accepted medical standards." The routine and accepted medical practice is for the attending physician to perform a gross (visual) examination of any tissue removed during an abortion. Only if the physician detects abnormalities is there a need to send a tissue sample to a pathologist. The American College of Obstetricians and

Gynecologists (ACOG) does not recommend an examination by a pathologist in every case:

> "In the situation of elective termination of pregnancy, the attending physician should record a description of the gross products. Unless definite embryonic or fetal parts can be identified, the products of elective interruptions of pregnancy must be submitted to a pathologist for gross and microscopic examination.
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> ". . . . Aspirated tissue should be examined to ensure the presence of villi or fetal parts prior to the patient's release from the facility. If villi or fetal parts are not identified with certainty, the tissue specimen must be sent for further pathologic examination. . . ." ACOG, Standards for Obstetric-Gynecologic Services 52, 54 (1982).[1]

Nor does the National Abortion Federation believe that such an examination is necessary:

> "All tissue must be examined grossly at the time of the abortion procedure by a physician or trained assistant and the results recorded in the chart. In the absence of visible fetal parts or placenta upon gross examination, obtained tissue may be examined under a low power microscope for the detection of villi. If this examination is inconclusive, the tissue should be sent to the nearest suitable pathology laboratory for microscopic examina-

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[1] See also ACOG, Standards for Obstetric-Gynecologic Services 66 (1982):

"Tissue removed should be submitted to a pathologist for examination. . . . An exception to the practice may be in elective terminations of pregnancy in which definitive embryonic or fetal parts can be identified. In such instances, the physician should record a description of the gross products. Unless definite embryonic or fetal parts can be identified, the products of elective interruptions of pregnancy must be submitted to a pathologist for gross and microscopic examination."

tion." National Abortion Federation Standards 6 (1981) (emphasis deleted).

As the Court of Appeals pointed out, there was expert testimony at trial that a nonpathologist physician is as capable of performing an adequate gross examination as is a pathologist, and that the "abnormalities which are of concern" are readily detectable by a physician. 655 F. 2d 848, 871, n. 37 (CA8 1981); see App. 135.[2] While a pathologist may be better able to perform a microscopic examination, Missouri law does not require a microscopic examination unless "fetal parts or placenta are not identified." 13 Mo. Admin. Code § 50–151.030(1) (1981). Thus, the effect of the Missouri statute is to require a pathologist to perform the initial gross examination, which is normally the responsibility of the attending physician and which will often make the pathologist's services unnecessary.

On the record before us, I must conclude that the State has not "met its burden of demonstrating that [the pathologist requirement] further[s] important health-related State concerns." *Akron*, *ante*, at 12.[3] There has been no showing that tissue examinations by a pathologist do more to protect health than examinations by a nonpathologist physician. Missouri does not require pathologists' reports for any other surgical procedures performed in clinics, or for minor surgery performed in hospitals. 13 Mo. Admin. Code § 50–20.030(3)(A)(7) (1977). Moreover, I cannot agree with JUSTICE POWELL that Missouri's pathologist requirement has "no significant impact" *ante*, at 13, on a woman's exercise of

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[2] The District Court made no findings on this point, noting only that some witnesses for the State had testified that "pathology should be done" for every abortion. 483 F. Supp. 679, 700, n. 49 (WD Mo. 1980).

[3] JUSTICE POWELL appears to draw support from the facts that "questionable practices" occur at some abortion clinics, while at others "the standards of medical practice . . . may not be the highest." *Ante*, at 12, n. 12. There is no evidence, however, that such questionable practices occur in Missouri.

her right to an abortion. It is undisputed that this requirement may increase the cost of a first-trimester abortion by as much as $40. See 483 F. Supp., at 700, n. 48. Although this increase may seem insignificant from the Court's comfortable perspective, I cannot say that it is equally insignificant to every woman seeking an abortion. For the woman on welfare or the unemployed teenager, this additional cost may well put the price of an abortion beyond reach.[4] Cf. *Harper* v. *Virginia Board of Elections*, 383 U. S. 663, 668 (1966) ($1.50 poll tax "excludes those unable to pay"); *Burns* v. *Ohio*, 360 U. S. 252, 255, 257 (1959) ($20 docket fee "foreclose[s] access" to appellate review for indigents).

In *Planned Parenthood of Central Mo.* v. *Danforth*, 428 U. S. 52, 81 (1976), the Court warned that the minor record-keeping requirements upheld in that case "perhaps approach[ed] impermissible limits." Today in *Akron*, we have struck down restrictions on first-trimester abortions that "may in some cases add to the cost of providing abortions." *Ante*, at 30; see *ante*, at 31–32. Missouri's requirement of a pathologist's report unquestionably adds significantly to the cost of providing abortions, and Missouri has not shown that it serves any substantial health-related purpose. Under these circumstances, I would hold that constitutional limits have been exceeded.

II

In Missouri, an abortion may be performed after viability only if necessary to preserve the life or health of the woman.

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[4] A $40 pathologist's fee may increase the price of a first-trimester abortion by 20% or more. See 655 F. 2d, at 869, n. 35 (cost of first-trimester abortion at Reproductive Health Services is $170); F. Jaffe, B. Lindheim, and P. Lee, Abortion Politics: Private Morality and Public Policy 36 (1981) (cost of first-trimester clinic abortion ranges from approximately $185 to $235); Henshaw, Freestanding Abortion Clinics: Services, Structure, Fees, 14 Family Planning Perspectives 248, 255 (1982) (average cost of first-trimester clinic abortion is $190); NAF Membership Directory 18–19 (1982/1983) (NAF clinics in Missouri charge $180 to $225 for first-trimester abortion).

Mo. Rev. Stat. § 188.030.1 (1983). When a post-viability abortion is performed, Missouri law provides that "there [must be] in attendance a [second] physician . . . who shall take control of and provide immediate medical care for a child born as a result of the abortion." Mo. Rev. Stat. § 188.030.3 (1983). The Court recognized in *Roe* v. *Wade*, 410 U. S., at 164–165, that a State's interests in preserving maternal health and protecting the potentiality of human life may justify regulation and even prohibition of post-viability abortions, except those necessary to preserve the life and health of the mother. But regulations governing post-viability abortions, like those at any other stage of pregnancy, must be "tailored to the recognized state interests." *Id.*, at 165; see *H.L.* v. *Matheson*, 450 U. S. 398, 413 (1981) ("statute plainly serves important state interests, [and] is narrowly drawn to protect only those interests"); *Roe*, 410 U. S., at 155 ("legislative enactments must be narrowly drawn to express only the legitimate state interests at stake").

A

The second physician requirement is upheld in this case on the basis that it "reasonably furthers the State's compelling interest in protecting the lives of viable fetuses." *Ante*, at 9. While I agree that a second physician indeed may aid in preserving the life of a fetus born alive, this type of aid is possible only when the abortion method used is one that may result in a live birth. Although Missouri ordinarily requires a physician performing a post-viability abortion to use the abortion method most likely to preserve fetal life, this restriction does not apply when this method "would present a greater risk to the life and health of the woman." Mo. Rev. Stat. § 188.030.2 (1983).

The District Court found that the dilatation and evacuation (D&E) method of abortion entails no chance of fetal survival, and that it will nevertheless be the method of choice for some women who need post-viability abortions. In some cases, in

other words, maternal health considerations will preclude the use of procedures that might result in a live birth. 483 F. Supp., at 694.[5] When a D&E abortion is performed, the second physician can do nothing to further the State's compelling interest in protecting potential life. His presence is superfluous. The second-physician requirement thus is overbroad and "imposes a burden on women in cases where the burden is not justified by any possibility of survival of the fetus." 655 F. 2d, at 865–866.

JUSTICE POWELL apparently believes that the State's interest in preserving potential life justifies the State in requiring a second physician at all post-viability abortions because some methods other than D&E may result in live births. But this fact cannot justify requiring a second physician to attend an abortion at which the chance of a live birth is nonexistent. The choice of method presumably will be made in ad-

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[5] The District Court relied on the testimony of Doctors Robert Crist and Richard Schmidt. Doctor Crist testified that in some instances abortion methods other than D&E would be "absolutely contraindicated" by the woman's health condition, 2 Record 438–439, giving the example of a recent patient with hemolytic anemia that would have been aggravated by the use of prostaglandins or other labor-inducing abortion methods, *id.*, at 428. Doctor Schmidt testified that "[t]here very well may be" situations in which D&E would be used because other methods were contraindicated. 4 Record 836. Although Doctor Schmidt previously had testified that a post-viability D&E abortion was "almost inconceivable," this was in response to a question by the State's attorney regarding whether D&E would be used "[a]bsent the possibility that there is extreme contraindication for the use of prostaglandins or saline, or of hysterotomy." *Id.*, at 787. Any inconsistencies in Doctor Schmidt's testimony apparently were resolved by the District Court in the plaintiffs' favor.

The Court of Appeals upheld the District Court's factual finding that health reasons sometimes would require the use of D&E for post-viability abortions. 665 F. 2d, at 865. Absent the most exceptional circumstances, we do not review a District Court's factual findings in which the Court of Appeals has concurred. *Branti* v. *Finkel*, 445 U. S. 507, 512, n. 6 (1980).

vance,[6] and any need for a second physician disappears when the woman's health requires that the choice be D&E. Because the statute is not tailored to protect the State's legitimate interests, I would hold it invalid.[7]

B

In addition, I would hold that the statute's failure to provide a clear exception for emergency situations renders it unconstitutional. As JUSTICE POWELL recognizes, *ante*, at 8, n. 8, an emergency may arise in which delay could be dangerous to the life or health of the woman. A second physician may not always be available in such a situation; yet the statute appears to require one. It states, in unqualified terms, that a post-viability abortion "*shall* be performed . . . *only* when there is in attendance" a second physician who "*shall* take control of" any child born as a result of the abortion, and it imposes certain duties on "the physician *required* by this

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[6] In addition to requiring the physician to select the method most likely to preserve fetal life, so long as it presents no greater risk to the pregnant woman, Missouri requires that the physician "certify in writing the available method or techniques considered and the reasons for choosing the method or technique employed." Mo. Rev. Stat. § 188.030.2 (1983). This ensures that the choice of method will be a reasoned one.

[7] The State argues that its second-physician requirement is justified even when D&E is used, because "[i]f the statute specifically excepted D&E procedures, abortionists would be encouraged to use it more frequently to avoid the expense of a second physician, to ensure a dead fetus, to prevent the presence of a second professional to observe malpractice or the choice of a questionable procedure from a safety viewpoint, a fetus-destroying procedure, or to avoid their own awakening to concern for the newborn." Brief for Cross-Petitioners in No. 81–1623, p. 44. The Court rejected this purported justification for a second physician in *Doe* v. *Bolton*, 410 U. S. 179, 199 (1973): "If a physician is licensed by the State, he is recognized by the State as capable of exercising acceptable clinical judgment. If he fails in this, professional censure and deprivation of his license are available remedies. Required acquiescence by co-practitioners has no rational connection with a patient's needs and unduly infringes on the physician's right to practice."

section to be in attendance." Mo. Rev. Stat. § 188.030.3 (emphasis added). By requiring the attendance of a second physician even when the resulting delay may be harmful to the health of the pregnant woman, the statute impermissibly fails to make clear "that the woman's life and health must always prevail over the fetus' life and health when they conflict." *Colautti* v. *Franklin*, 439 U. S. 379, 400 (1979).

JUSTICE POWELL attempts to cure this defect by asserting that the final clause of the statute, requiring the two physicians to "take all reasonable steps . . . to preserve the life and health of the viable unborn child; provided that it does not pose an increased risk to the life or health of the woman," could be construed to permit emergency post-viability abortions without a second physician. *Ante*, at 8, n. 8. This construction is contrary to the plain language of the statute; the clause upon which JUSTICE POWELL relies refers to the duties of both physicians during the performance of the abortion, but it in no way suggests that the second physician may be dispensed with.

Moreover, since JUSTICE POWELL's proposed construction is not binding on the courts of Missouri,[*] a physician performing an emergency post-viability abortion cannot rely on it with any degree of confidence. The statute thus remains impermissibly vague; it fails to inform the physician whether he may proceed with a post-viability abortion in an emergency, or whether he must wait for a second physician even if the woman's life or health will be further imperiled by the delay. This vagueness may well have a severe chilling effect on the physician who perceives the patient's need for a post-viability abortion. In *Colautti* v. *Franklin*, we considered a statute that failed to specify whether it "require[d] the physi-

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[*] "Only the [Missouri] courts can supply the requisite construction, since of course 'we lack jurisdiction authoritatively to construe state legislation.'" *Gooding* v. *Wilson*, 405 U. S. 518, 520 (1972), quoting *United States* v. *Thirty-seven Photographs*, 402 U. S. 363, 369 (1971).

cian to make a 'trade-off' between the woman's health and additional percentage points of fetal survival." 439 U. S., at 400. The Court held there that "where conflicting duties of this magnitude are involved, the State, at the least, must proceed with greater precision before it may subject a physician to possible criminal sanctions." *Id.*, at 400–401.[9] I would apply that reasoning here, and hold Missouri's second-physician requirement invalid on this ground as well.[10]

III

Missouri law prohibits the performance of an abortion on an unemancipated minor absent parental consent or a court order. Mo. Rev. Stat. § 188.028 (1983).

Until today, the Court has never upheld "a requirement of a consent substitute, either parental or judicial," *ante*, at 14. In *Planned Parenthood of Central Mo.* v. *Danforth*, 428 U. S., at 74, the Court invalidated a parental consent requirement on the ground that "the State does not have the

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[9] A physician who fails to comply with Missouri's second-physician requirement faces criminal penalties and the loss of his license. Mo. Rev. Stat. §§ 188.065, 188.075 (1983).

[10] Because I would hold the statute unconstitutional on these grounds, I do not reach the question whether Missouri's second-physician requirement impermissibly interferes with the doctor-patient relationship. I note, however, that Missouri does not require attendance of a second physician at any other medical procedure, including a premature birth. There was testimony at trial that a newborn infant, whether the product of a normal birth or an abortion, ordinarily remains the responsibility of the woman's physician until he turns its care over to another. App. 133; see ACOG, Standards for Obstetric-Gynecologic Services 31 (1982) ("The individual who delivers the baby is responsible for the immediate post-delivery care of the newborn until another person assumes this duty").

This allocation of responsibility makes sense. Consultation and teamwork are fundamental in medical practice, but in an operating room a patient's life or health may depend on split-second decisions by the physician. If responsibility and control must be shared between two physicians with the lines of authority unclear, precious moments may be lost to the detriment of both woman and child.

constitutional authority to give a third party an absolute, and possibly arbitrary, veto over the decision of the physician and his patient, regardless of the reason for withholding the consent." In *Bellotti* v. *Baird*, 443 U. S. 622 (1979) (*Bellotti II*), eight Justices agreed that a Massachusetts statute permitting a judicial veto of a mature minor's decision to have an abortion was unconstitutional. See *id.*, at 649–650 (opinion of POWELL, J.); *id.*, at 654–656 (opinion of STEVENS, J.). Although four Justices stated in *Bellotti II* that an appropriately structured judicial consent requirement would be constitutional, *id.*, at 647–648 (opinion of POWELL, J.), this statement was not necessary to the result of the case and did not command a majority. Four other Justices concluded that any judicial-consent statute would suffer from the same flaw the Court identified in *Danforth*: it would give a third party an absolute veto over the decision of the physician and his patient. *Id.*, at 655–656 (opinion of STEVENS, J.).

I continue to adhere to the views expressed by JUSTICE STEVENS in *Bellotti II*:

> "It is inherent in the right to make the abortion decision that the right may be exercised without public scrutiny and in defiance of the contrary opinion of the sovereign or other third parties. . . . As a practical matter, I would suppose that the need to commence judicial proceedings in order to obtain a legal abortion would impose a burden at least as great as, and probably greater than, that imposed on the minor child by the need to obtain the consent of the parent. Moreover, once this burden is met, the only standard provided for the judge's decision is the best interest of the minor. That standard provides little real guidance to the judge, and his decision must necessarily reflect personal and societal values and mores whose enforcement upon the minor—particularly when contrary to her own informed and reasonable decision—is fundamentally at odds with privacy interests underly-

> ing the constitutional protection afforded to her decision." 443 U. S., at 655–656 (footnote omitted).

Because Mo. Rev. Stat. § 188.028 permits a parental or judicial veto of a minor's decision to obtain an abortion, I would hold it unconstitutional.

NOTE: Where it is feasible, a syllabus (headnote) will be released, as is being done in connection with this case, at the time the opinion is issued. The syllabus constitutes no part of the opinion of the Court but has been prepared by the Reporter of Decisions for the convenience of the reader. See *United States* v. *Detroit Lumber Co.*, 200 U. S. 321, 337.

SUPREME COURT OF THE UNITED STATES

Syllabus

SIMOPOULOS *v.* VIRGINIA

APPEAL FROM THE SUPREME COURT OF VIRGINIA

No. 81–185. Argued November 30, 1982—Decided June 15, 1983

Appellant, an obstetrician-gynecologist, was convicted after a Virginia state-court trial for violating Virginia statutory provisions that make it unlawful to perform an abortion during the second trimester of pregnancy outside of a licensed hospital. "Hospital" is defined to include outpatient hospitals, and State Department of Health regulations define "outpatient hospital" as including institutions that primarily furnish facilities for the performance of surgical procedures on outpatients. The regulations also provide that second-trimester abortions may be performed in an outpatient surgical clinic licensed as a "hospital" by the State. The evidence at appellant's trial established, *inter alia*, that he performed a second-trimester abortion on an unmarried minor by an injection of saline solution at his unlicensed clinic; that the minor understood appellant to agree to her plan to deliver the fetus in a motel and did not recall being advised to go to a hospital when labor began, although such advice was included in an instruction sheet provided her by appellant; and that the minor, alone in a motel, aborted her fetus 48 hours after the saline injection. The Virginia Supreme Court affirmed appellant's conviction.

Held:

1. The Virginia abortion statute was not unconstitutionally applied to appellant on the asserted ground that the State failed to allege in the indictment and to prove lack of medical necessity for the abortion. Under the authoritative construction of the statute by the Virginia Supreme Court, the prosecution was not obligated to prove lack of medical necessity beyond a reasonable doubt *until* appellant invoked medical necessity as a defense. Placing upon the defendant the burden of going forward with evidence on an affirmative defense is normally permissible. And appellant's contention that the prosecution failed to prove that his acts in fact caused the fetus' death is meritless, in view of the undisputed facts proved at trial. Pp. 3–4.

Syllabus

2. Virginia's requirement that second-trimester abortions be performed in licensed outpatient clinics is not an unreasonable means of furthering the State's important and legitimate interest in protecting the woman's health, which interest becomes "compelling" at approximately the end of the first trimester. In *Akron* v. *Akron Center for Reproductive Health, Inc.*, *ante*, p. ——, and *Planned Parenthood Assn. of Kansas City* v. *Ashcroft*, *ante*, p. ——, constitutional challenges were upheld with regard to requirements mandating that all second-trimester abortions be performed in "general, acute-care facilities." In contrast, the Virginia statutes and regulations do not require that such abortions be performed exclusively in full-service hospitals, but permit their performance at licensed outpatient clinics. Thus, the decisions in *Akron* and *Ashcroft* are not controlling here. Although a State's discretion in determining standards for the licensing of medical facilities does not permit it to adopt abortion regulations that depart from accepted medical practice, the Virginia regulations on their face are compatible with accepted medical standards governing outpatient second-trimester abortions. Pp. 4–13.

221 Va. 1059, 227 S. E. 2d 194, affirmed.

POWELL, J., delivered the opinion of the Court, in which BURGER, C. J., and BRENNAN, MARSHALL, and BLACKMUN, JJ., joined, and in Parts I and II of which WHITE, REHNQUIST, and O'CONNOR, JJ., joined. O'CONNOR, J., filed an opinion concurring in part and concurring in the judgment, in which WHITE and REHNQUIST, JJ., joined. STEVENS, J., filed a dissenting opinion.

NOTICE: This opinion is subject to formal revision before publication in the preliminary print of the United States Reports. Readers are requested to notify the Reporter of Decisions, Supreme Court of the United States, Washington, D. C. 20543, of any typographical or other formal errors, in order that corrections may be made before the preliminary print goes to press.

SUPREME COURT OF THE UNITED STATES

No. 81–185

CHRIS SIMOPOULOS, APPELLANT *v.* VIRGINIA

ON APPEAL FROM THE SUPREME COURT OF VIRGINIA

[June 15, 1983]

JUSTICE POWELL delivered the opinion of the Court.

We have considered today mandatory hospitalization requirements for second-trimester abortions in *City of Akron* v. *Akron Center for Reproductive Health, Inc.*, *ante*, p. ——, and *Planned Parenthood Assn. of Kansas City, Mo., Inc.* v. *Ashcroft*, *ante*, p. ——. The principal issue here is whether Virginia's mandatory hospitalization requirement is constitutional.

I

Appellant is a practicing obstetrician-gynecologist certified by the American Board of Obstetrics and Gynecology. In November, 1979, he practiced at his office in Woodbridge, Virginia, at four local hospitals, and at his clinic in Falls Church, Virginia. The Falls Church clinic has an operating room and facilities for resuscitation and emergency treatment of cardiac/respiratory arrest. Replacement and stabilization fluids are on hand. Appellant customarily performs first-trimester abortions at his clinic. During the time relevant to this case, the clinic was not licensed, nor had appellant sought any license for it.

P.M. was a 17-year old high-school student when she went to appellant's clinic on November 8, 1979. She was unmarried, and told appellant that she was approximately 22 weeks pregnant. She requested an abortion but did not want her parents to know. Examination by appellant confirmed that

P.M. was five months pregnant, well into the second trimester. Appellant testified that he encouraged her to confer with her parents and discussed with her the alternative of continuing the pregnancy to term. She did return home, but never advised her parents of her decision.

Two days later, P.M. returned to the clinic with her boy friend. The abortion was performed by an injection of saline solution. P.M. told appellant that she planned to deliver the fetus in a motel, and understood him to agree to this course. Appellant gave P.M. a prescription for an analgesic and a "Post-Injection Information" sheet that stated that she had undergone "a surgical procedure" and warned of a "wide range of normal reactions." App. 199. The sheet also advised that she call the physician if "heavy" bleeding began. Although P.M. did not recall being advised to go to a hospital when labor began, this was included on the instruction sheet. *Id.*, at 200.

P.M. went to a motel. Alone, she aborted her fetus in the motel bathroom 48 hours after the saline injection. She left the fetus, follow-up instructions, and pain medication in the wastebasket at the motel. Her boy friend took her home. Police found the fetus later that day and began an investigation.[1]

Appellant was indicted[2] for unlawfully performing an abortion during the second trimester of pregnancy outside of

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[1] Except as permitted by statute, persons performing an abortion are guilty of a Class 4 felony under Virginia law and subject to mandatory license revocation. Va. Code §§ 18.2–71, 54–316(3), 54–317(1), 54.321.2 (1982). A Class 4 felony is punishable by a sentence of two to ten years in prison. Va. Code § 18.2–10(d).

[2] The indictment alleges a violation of Va. Code § 18.2–71, which provides:

"Except as provided in other sections of this article, if any person administer to, or cause to be taken by a woman, any drug or other thing, or use means, with intent to destroy her unborn child, or to produce abortion or miscarriage, and thereby destroy such child, or produce such abortion or

a licensed hospital and was convicted by the Circuit Court of Fairfax County sitting without a jury. The Supreme Court of Virginia unanimously affirmed the conviction. *Simopoulos* v. *Commonwealth*, 221 Va. 1059, 277 S. E. 2d 194 (1981). This appeal followed. We noted probable jurisdiction, 456 U. S. 988, and now affirm.

II

Appellant raises two issues that do not require extended treatment. He first contends that Va. Code § 18.2–71 was applied unconstitutionally to him, because lack of medical necessity for the abortion was not alleged in the indictment, addressed in the prosecution's case, or mentioned by the trier of fact. Appellant contends that this failure renders his conviction unconstitutional for two reasons: (i) the State failed to meet its burden of alleging necessity in the indictment, as required by *United States* v. *Vuitch*, 402 U. S. 62 (1971); and (ii) the prosecution failed to meet its burden of persuasion, as required by *Patterson* v. *New York*, 432 U. S. 197 (1977).

The authoritative construction of § 18.2–71 by the Supreme Court of Virginia makes it clear that, at least with respect to the defense of medical necessity, the prosecution was not obligated to prove lack of medical necessity beyond a reasonable doubt *until* appellant invoked medical necessity as a defense. See 221 Va., at 1069, 277 S. E. 2d, at 200. Appellant's reliance on *Vuitch* thus is misplaced: the District of Co-

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miscarriage, he shall be guilty of a Class 4 felony."

The Virginia Code sets forth four exceptions to this statute: there is no criminal liability if the abortion (i) is performed within the first trimester, § 18.2–72; (ii) is performed in a licensed hospital in the second trimester, § 18.2–73; (iii) is performed during the third trimester under certain circumstances, § 18.2–74; and (iv) is necessary to save the woman's life, § 18.2–74.1. The indictment here alleged a violation of § 18.2–71 and expressly negated any defense of hospitalization under § 18.2–73 and any first-trimester defense under § 18.2–72. The indictment did not, however, rebut the other defenses.

lumbia statute in *Vuitch*, as construed by this Court, required the prosecution to make this allegation. See 402 U. S., at 70. Placing upon the defendant the burden of going forward with evidence on an affirmative defense is normally permissible. See *Engle* v. *Isaac*, 456 U. S. 107, 120–121, and n. 20 (1982); *Mullaney* v. *Wilbur*, 421 U. S. 684, 701–703, nn. 28, 30, 31 (1975).

Appellant also contends that the prosecution failed to prove that his acts in fact caused the death of the fetus. In view of the undisputed facts proved at trial, summarized above, this contention is meritless. See 221 Va., at 1069–1070, 277 S. E. 2d, at 200–201.

III

We consistently have recognized and reaffirm today that a State has an "important and legitimate interest in the health of the mother" that becomes "'compelling' . . . at approximately the end of the first trimester." *Roe* v. *Wade*, 410 U. S. 113, 163 (1973). See *City of Akron*, *ante*, at 10. This interest embraces the facilities and circumstances in which abortions are performed. See *id.*, at 150. Appellant argues, however, that Virginia prohibits all non-hospital second-trimester abortions and that such a requirement imposes an unconstitutional burden on the right of privacy. In *City of Akron* and *Ashcroft*, we upheld such a constitutional challenge to the acute-care hospital requirements at issue there. The State of Virginia argues here that its hospitalization requirement differs significantly from the hospitalization requirements considered in *City of Akron* and *Ashcroft* and that it reasonably promotes the State's interests.

A

In furtherance of its compelling interest in maternal health, Virginia has enacted a hospitalization requirement for abortions performed during the second trimester. As a general proposition, physicians' offices are not regulated under

Virginia law.[3] Virginia law does not, however, permit a physician licensed in the practice of medicine and surgery to perform an abortion during the second trimester of pregnancy unless "such procedure is performed in a hospital licensed by the State Department of Health." Va. Code § 18.2–73 (1982). The Virginia abortion statute itself does not define the term "hospital." This definition is found in Va. Code § 32.1–123.1,[4] that defines "hospital" to include

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[3] A physician's office is explicitly excluded from the hospital licensing statutes and regulations unless the office is used principally for performing surgery. Va. Code § 32.1–124(5). "Surgery" is not defined. Appellant contends that whether his facility principally performs surgery is a question of fact that has not been resolved, and that it is uncertain whether his clinic may be licensed as a "hospital." He notes that *after* he performed the abortion on P.M. he requested a certificate of need, see *id.*, § 32.1–102.3, but was informed by the Office of the Attorney General that his "clinic-office cannot be licensed as a hospital" and that "if you wish to perform this type of procedure, you must, in essence, build a hospital to do it." App. to Reply Brief for Appellant 3a, 4a. Appellant did not seek a license before he performed the abortion at issue here, nor does he now argue that his clinic would meet the requirements of the Virginia statute and regulations. Rather, he broadly attacks the validity of the state hospitalization requirements as applied to second-trimester abortions. Thus, it is irrelevant to the issue before us whether appellant's clinic and his procedures would have complied with the Virginia regulations.

[4] The Supreme Court of Virginia views the word "hospital" in § 18.2–73 as referring to the definition of that term in § 32.1–123.1. This is made clear by the court's general reference in its opinion to title 32.1 of the Virginia Code, the title of the Code that contains many of Virginia's health laws:

"The state is empowered to license and regulate hospitals, clinics, home health agencies, and other medical care facilities, *see generally*, Title 32.1 of the Code, and to fix and enforce different standards of medical care for different facilities. The General Assembly has decided that medical procedures employed in second-trimester abortions must be performed in hospitals. Based upon the evidence in this record, we are of the opinion that the hospital requirement is reasonably related to the State's compelling interest in preserving and protecting maternal health." 221 Va., at 1075, 277 S. E. 2d, at 204.

"outpatient . . . hospitals."[5] Section 20.2.11 of the Department of Health's Rules and Regulations for the Licensure of Outpatient Hospitals in Virginia (1977) ("regulations")[6] defines outpatient hospital in pertinent part as "[i]nstitutions

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There is no basis for assuming that the court interpreted "hospital" in § 18.2–73 any differently from its interpretation in title 32.1, and specifically in § 32.1–123.1. See n. 5, *infra*.

[5] Section 32.1–123.1 provides:

"'*Hospital*' means any facility in which the primary function is the provision of diagnosis, of treatment, and of medical and nursing services, surgical or nonsurgical, for two or more nonrelated individuals, including hospitals known by varying nomenclature or designation such as sanatoriums, sanitariums and general, acute, short-term, long-term, outpatient and maternity hospitals."

The definition of hospital in effect in 1975 when § 18.2–73 was enacted is similar. See Va. Code § 32.298(2) (1973) (repealed by 1979 Acts, c. 711). It specifically included at that time "out-patient surgical hospitals (which term shall not include the office or offices of one or more physicians or surgeons unless such office or offices are used principally for performing surgery)."

[6] The regulations were promulgated pursuant to the State Board of Health's general authority to adopt rules and regulations prescribing minimum standards for hospitals. This authority permits it to

"classify hospitals in accordance with the character of treatment, care, or service rendered or offered, and prescribe the minimum standards and requirements for each class in conformity with provisions of this chapter, with the guiding principles expressed or implied herein, and with due regard to and in reasonable conformity to the standards of health, hygiene, sanitation, and safety as established and recognized by the medical profession and by specialists in matters of public health and safety, having due regard to the availability of physicians, surgeons, nurses and other assistants, and the cost and expense to the hospital and the resulting costs to the patients." Va. Code § 32–301 (1973) (repealed by 1979 Acts, c. 711) (similar rulemaking authority currently is granted in Va. Code §§ 32.1–12 and 32.1–127 (1979)).

The first draft of the regulations differed considerably from the regulations that the Board finally approved. See Department of Health, Draft I, Rules and Regulations for the Licensure of Outpatient Hospitals in Virginia (October 27, 1976). The most important difference was that the requirements now in Part II of the regulations were applicable to all outpa-

. . . which primarily provide facilities for the performance of surgical procedures on outpatients"[7] and provides that second-trimester abortions may be performed in these clinics.[8] Thus, under Virginia law, a second-trimester abortion may

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tient facilities in which abortions could be performed, regardless of the trimester.

[7] The State Board of Health gave preliminary approval to the proposed regulations on December 1, 1976, and a public hearing was held January 26, 1977. Dr. William R. Hill, a member of the Board, presided at this hearing, and staff present from the Department included two doctors and the Director of the Bureau of Medical and Nursing Facilities Services. Witnesses included the Associate Executive Director of the Virginia Hospital Association; a representative of five outpatient abortion clinics in the State; representatives of two abortion clinics, the Richmond Medical Center and the Hillcrest Clinic; a professor from Eastern Virginia Medical School representing Planned Parenthood of Southside Tidewater and the Tidewater OBGYN Society; the Medical Director of the Ambulatory Surgical Center of Leigh Memorial Hospital; the Administrator of Leigh Memorial Hospital; a representative of the Virginia Society for Human Life; and a representative of the Northern Virginia Medical Center. See Commonwealth of Virginia Department of Health, Public Hearing In Re: Proposed Rules and Regulations for the Licensure of Outpatient Hospitals in Virginia (January 26, 1977). The Executive Director of the Virginia Hospital Association stated that "[i]n general, they are a good set of standards and have our support." *Id.*, at 4. The abortion clinics were concerned, however, about the imposition of the regulations on outpatient abortion clinics then performing first-trimester abortions. The clinics acknowledged that during the second trimester "the State may regulate the [abortion] procedure in the interest of maternal health." *Id.*, at 7. But the clinics specifically "propose[d] that clinics or other facilities that perform abortions during the first trimester be specifically excluded from the Rules and Regulations for the Licensure of Outpatient Hospitals in Virginia." *Id.*, at 26. See also *id.*, at 28. The Medical Director of the Ambulatory Surgical Center of Leigh Memorial Hospital, concerned about the need to set high standards for outpatient surgical hospitals in the State, agreed that the Board should not "compromise" the strict standards needed for outpatient surgical hospitals in order to include these first-trimester outpatient abortion clinics within the same set of regulations. See *id.*, at 30. Following the hearing, the Board added Part III, the regulations of which apply only

[Footnotes 7 and 8 are on page 8]

be performed in an outpatient surgical hospital provided that facility has been licensed as a "hospital" by the State.

The Virginia regulations applicable to the performance of second-trimester abortions in outpatient surgical hospitals are, with few exceptions, the same regulations applicable to all outpatient surgical hospitals in Virginia, and may be grouped for purposes of discussion into three main categories. The first grouping relates to organization, manage-

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to clinics doing first-trimester abortions. See nn. 8, 12, *infra*. It therefore is clear that Virginia has recognized the need for discrete and different sets of regulations for the two periods. The Board gave its final approval, and the regulations became effective on June 30, 1977. The abortion for which appellant was prosecuted was performed on November 10, 1979, some two years and five months later.

We note that new but similar regulations now supersede the regulations in effect when appellant performed the abortion for which he was prosecuted. See Department of Health, Rules and Regulations for the Licensure of Hospitals in Virginia, pt. IV (1982). These new regulations were promulgated pursuant to Va. Code §§ 32.1–12, 32.1–127, enacted in 1979.

[7] Section 32.1–125 of the Code provides: "No person shall establish, conduct, maintain, or operate in this Commonwealth any hospital . . . unless such hospital . . . is licensed as provided in this article." See also Va. Regs. (Outpatient Hospitals) § 30.1 (similar provision specifically governing outpatient surgical hospitals).

[8] Part II of the regulations sets minimum standards for outpatient surgical hospitals that may perform second-trimester abortions. This interpretation is confirmed by several sections in Part II, *i. e.*, §§ 43.6.2, 43.6.3, 43.7.3(c), 43.8.4, 43.8.5, 43.9.5, all of which refer to abortion services, and by the history of Part III, see n. 6, *supra*. Moreover, the State's counsel at oral argument represented that facilities licensed pursuant to Part II legally may perform second-trimester abortions. Tr. of Oral Arg. 33.

Virginia uses the term "outpatient abortion clinics" to refer specifically to those facilities meeting the minimum standards of Part III of the regulations. See Va. Regs. (Outpatient Hospitals), p. i. Facilities meeting these standards are limited to performing abortions only during the first trimester of pregnancy. *Ibid.* See *id.*, § 62.1.2 ("Any procedure performed to terminate a pregnancy [in an outpatient abortion clinic] shall be performed prior to the end of the first trimester (12th week amenorrhea).").

ment, policies, procedures, and staffing. These regulations require personnel and facilities "necessary to meet patient and program needs." Va. Regs. (Outpatient Hospitals) § 40.3; see also § 40.1. They also require a policy and procedures manual, § 43.2, an administrative officer, § 40.6, a licensed physician who must supervise clinical services and perform surgical procedures, § 42.1, and a registered nurse to be on duty at all times while the facility is in use, § 42.2. The second category of requirements outlines construction standards for outpatient surgical clinics, but also provides that "deviations from the requirements prescribed herein may be approved if it is determined that the purposes of the minimum requirements have been fulfilled," § 50.2.1. There are also construction requirements that set forth standards for the public areas, clinical areas, laboratory and radiology services, §§ 52.1, 52.2, 52.3, and general building, §§ 50.6.1, 50.7.1, 50.8.1, 52.4. The final group of regulations relates to patient care services. Most of these set the requirements for various services that the facility may offer, such as anesthesia, § 43.1, laboratory, §§ 43.6.1, 64.1.3, 64.1.4, and pathology, §§ 43.6.3, 64.2.4. Some of the requirements relate to sanitation, laundry, and the physical plant. §§ 43.2, 43.10, 43.11, 43.12.6. There are also guidelines on medical records, § 43.7, pre-operative admission, § 43.8, and post-operative recovery, § 43.9. Finally, the regulations mandate some emergency services and evacuation planning. §§ 43.4.1, 43.5.

B

It is readily apparent that Virginia's second-trimester hospitalization requirement differs from those at issue in *City of Akron*, *ante*, at 13, and *Planned Parenthood Assn. of Kansas City, Mo., Inc.* v. *Ashcroft*, *ante*, at 4–5. In those cases, we recognized the medical fact that, "at least during the early weeks of the second trimester[,] D&E abortions may be performed as safely in an outpatient clinic as in a full-service hospital." *City of Akron*, *ante*, at 19. The requirements at

issue, however, mandated that "all second-trimester abortions must be performed in general, acute-care facilities." *Ashcroft*, *ante*, at 5. In contrast, the Virginia statutes and regulations do not require that second-trimester abortions be performed exclusively in full-service hospitals. Under Virginia's hospitalization requirement, outpatient surgical hospitals may qualify for licensing as "hospitals" in which second-trimester abortions lawfully may be performed. Thus, our decisions in *City of Akron* and *Ashcroft* are not controlling here.

In view of its interest in protecting the health of its citizens, the State necessarily has considerable discretion in determining standards for the licensing of medical facilities. Although its discretion does not permit it to adopt abortion regulations that depart from accepted medical practice, it does have a legitimate interest in regulating second-trimester abortions and setting forth the standards for facilities in which such abortions are performed.

On their face, the Virginia regulations appear to be generally compatible with accepted medical standards governing outpatient second-trimester abortions. The American Public Health Association (APHA), although recognizing "that greater use of the dilatation and evacuation procedure make[s] it possible to perform the vast majority of second trimester abortions during or prior to the 16th [w]eek after the last menstrual period," still "[u]rges endorsement of the provision of second trimester abortion in free-standing qualified clinics that meet the state standards required for certification." APHA, The Right to Second Trimester Abortion 1, 2 (1979). The medical profession has not thought that a State's standards need be relaxed merely because the facility performs abortions: "Ambulatory care facilities providing abortion services should meet the same standards of care as those recommended for other surgical procedures performed in the physician's office and outpatient clinic or the free-standing and hospital-based ambulatory setting." American

College of Obstetricians and Gynecologists (ACOG), Standards for Obstetric-Gynecologic Services 54 (5th ed. 1982). See also *id.*, at 52 ("Free-standing or hospital-based ambulatory surgical facilities should be licensed to conform to requirements of state or federal legislation."). Indeed, the medical profession's standards for outpatient surgical facilities are stringent: "Such facilities should maintain the same surgical, anesthetic, and personnel standards as recommended for hospitals." *Ibid.*

We need not consider whether Virginia's regulations are constitutional in every particular. Despite personal knowledge of the regulations at least by the time of trial, appellant has not attacked them as being insufficiently related to the State's interest in protecting health.[9] His challenge throughout this litigation appears to have been limited to an assertion that the State cannot require all second-trimester abortions to be performed in full-service general hospitals. In essence, appellant has argued that Virginia's hospitalization requirements are no different in substance from those reviewed in the *City of Akron* and *Ashcroft* cases.[10] At the

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[9] See nn. 3, 6, *supra*; 5 Record 55–56 (appellant acknowledging existence of the outpatient hospital license; stating that he was seeking a license; but denying that he knew of the licensing program when the abortion was performed).

[10] Appellant's reply brief does criticize the Virginia regulations, but not individually or on specific grounds, instead making only facial challenges in the broadest language and in conclusory terms: that the record is silent on the applicability of those regulations to his facility; that the record does not show whether any outpatient surgical hospitals exist in Virginia or whether, if they exist, they allow second-trimester abortions; that the record is silent on the reasonableness of the regulations; that he had no opportunity to defend against the regulations at trial; that it is uncertain whether, if he had applied for an outpatient hospital license, it would have been granted; that obtaining a license is an arduous process; that Virginia courts have had no opportunity to construe the "licensing statutes and regulations"; and that Part II of the regulations does not cover an outpatient surgical hospital where second-trimester abortions are performed.

same time, however, appellant took the position—both before the Virginia courts and this Court—that a state licensing requirement for outpatient abortion facilities would be constitutional.[11] We can only assume that by continuing to challenge the Virginia hospitalization requirement petitioner either views the Virginia regulations in some unspecified way as unconstitutional or challenges a hospitalization requirement that does not exist in Virginia. Yet, not until his reply brief in this Court did he elect to criticize the regulations apart from his broadside attack on the entire Virginia hospitalization requirement.

Given the plain language of the Virginia regulations and the history of their adoption, see n. 6, *supra*, we see no reason to doubt that an adequately equipped clinic could, upon proper application, obtain an outpatient hospital license permitting the performance of second-trimester abortions. We conclude that Virginia's requirement that second-trimester abortions be performed in licensed clinics is not an unreasonable means of furthering the State's compelling interest in "protecting the woman's own health and safety." *Roe*, 410 U. S., at 150.[12] As we emphasized in *Roe*, "[t]he State has a legitimate interest in seeing to it that abortion, like any other medical procedure, is performed under circumstances that in-

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Some of these arguments are simply meritless, see n. 8, *supra*, and others are irrelevant, see n. 3, *supra*, and none has been raised below.

[11] See 8 Record 196a, 214a; Brief for Appellant in No. 801107 (Va. S. Ct.), p. 35; Juris. Statement 16; Brief for Appellant 32, 43 n. 75, 46.

[12] Appellant argues that Part III of the regulations, covering first-trimester abortion clinics, requires the *same* services and equipment as Part II. In fact, Part III has detailed regulations that do not appear in Part II. See, *e. g.*, Va. Regs. (Outpatient Hospitals) §§ 63.1.1(b), § 63.3, 64.2.5(a)-(m). Appellant contends that, given these extensive regulations for first-trimester abortion clinics, the only way to require *more* technological support for second-trimester abortions would be to restrict them to acute-care, general hospitals. The only issue before us, however, relates to second-trimester abortions.

sure maximum safety for the patient." *Ibid.* Unlike the provisions at issue in *City of Akron* and *Ashcroft*, Virginia's statute and regulations do not require that the patient be hospitalized as an inpatient or that the abortion be performed in a full-service, acute-care hospital. Rather, the State's requirement that second-trimester abortions be performed in licensed clinics appears to comport with accepted medical practice, and leaves the method and timing of the abortion precisely where they belong—with the physician and the patient.

IV

The judgment of the Supreme Court of Virginia is

Affirmed.

SUPREME COURT OF THE UNITED STATES

No. 81–185

CHRIS SIMOPOULOS, APPELLANT *v.* VIRGINIA

ON APPEAL FROM THE SUPREME COURT OF VIRGINIA

[June 15, 1983]

JUSTICE O'CONNOR, with whom JUSTICE WHITE and JUSTICE REHNQUIST join, concurring in part and concurring in the judgment.

I agree with the Court's treatment of the appellant's arguments based on *United States* v. *Vuitch*, 402 U. S. 62 (1971) and *Patterson* v. *New York*, 432 U. S. 197 (1977). Accordingly, I join parts I and II of the Court's opinion.

I concur in the judgment of the Court insofar as it affirms the conviction. For reasons stated in my dissent in No. 81–746, *Akron* v. *Akron Center for Reproductive Health* and in No. 81–1172, *Akron Center for Reproductive Health* v. *Akron*, I do not agree that the constitutional validity of the Virginia mandatory hospitalization requirement is contingent in any way on the trimester in which it is imposed. Rather, I believe that the requirement in this case is not an undue burden on the decision to undergo an abortion.

NOTE: Where it is feasible, a syllabus (headnote) will be released, as is being done in connection with this case, at the time the opinion is issued. The syllabus constitutes no part of the opinion of the Court but has been prepared by the Reporter of Decisions for the convenience of the reader. See *United States* v. *Detroit Lumber Co.*, 200 U. S. 321, 337.

SUPREME COURT OF THE UNITED STATES

Syllabus

PLANNED PARENTHOOD ASSOCIATION OF KANSAS CITY, MISSOURI, INC., ET AL. *v.* ASHCROFT, ATTORNEY GENERAL OF MISSOURI, ET AL.

CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

No. 81–1255. Argued November 30, 1982—Decided June 15, 1983 *

Missouri statutes require abortions after 12 weeks of pregnancy to be performed in a hospital (§ 188.025); require a pathology report for each abortion performed (§ 188.047); require the presence of a second physician during abortions performed after viability (§ 188.030.3); and require minors to secure parental consent or consent from the juvenile court for an abortion (§ 188.028). In an action challenging the constitutionality of these provisions, the District Court invalidated all provisions except § 188.047. The Court of Appeals reversed as to §§ 188.028 and 188.047 but affirmed as to §§ 188.030.3 and 188.025.

Held: Section 188.025 is unconstitutional, but §§ 188.047, 188.030.3, and 188.028 are constitutional.

655 F. 2d 848, affirmed in part, reversed in part, vacated in part, and remanded; 664 F. 2d 687, affirmed.

JUSTICE POWELL delivered the opinion of the Court with respect to Parts I, II, and VI, concluding that the second-trimester hospitalization requirement of § 188.025 "unreasonably infringes upon a woman's constitutional right to obtain an abortion." *City of Akron* v. *Akron Center of Reproductive Health, Inc.*, *ante*, at ——. Pp. 4–5.

JUSTICE POWELL, joined by THE CHIEF JUSTICE, concluded in Parts III, IV, and V that:

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*Together with No. 81–1623, *Ashcroft, Attorney General of Missouri, et al.* v. *Planned Parenthood Association of Kansas City, Missouri, Inc., et al.*, also on certiorari to the same court.

Syllabus

1. The second-physician requirement of § 188.030.3 is constitutional as reasonably furthering the State's compelling interest in protecting the lives of viable fetuses. Pp. 5–9.

2. The pathology-report requirement of § 188.047 is constitutional. On its face and in effect, such requirement is reasonably related to generally accepted medical standards and furthers important health-related state concerns. In light of the substantial benefits that a pathologist's examination can have, the small additional cost of such an examination does not significantly burden a pregnant woman's abortion decision. Pp. 9–14.

3. Section 188.028 is constitutional. A State's interest in protecting immature minors will sustain a requirement of a consent substitute, either parental or judicial. And as interpreted by the Court of Appeals to mean that the juvenile court cannot deny a minor's application for consent to an abortion "for good cause" unless the court first finds that the minor was not mature enough to make her own decision, § 188.028 provides a judicial alternative that is consistent with established legal standards. See *City of Akron* v. *Akron Center for Reproductive Health, Inc.*, *ante*, at ——. Pp. 14–17.

JUSTICE O'CONNOR, joined by JUSTICE WHITE and JUSTICE REHNQUIST, concluded that:

1. The second-physician requirement of § 188.030.3 is constitutional because the State has a compelling interest, extant throughout pregnancy, in protecting and preserving fetal life. P. 2.

2. The pathology-report requirement of § 188.047 is constitutional because it imposes no undue burden on the limited right to undergo an abortion, and its validity is not contingent on the trimester of pregnancy in which it is imposed. P. 2.

3. Assuming, *arguendo*, that the State cannot impose a parental veto on a minor's decision to undergo an abortion, the parental consent provision of § 188.028.2 is constitutional because it imposes no undue burden on any right that a minor may have to undergo an abortion. P. 2.

POWELL, J., announced the Court's judgment and delivered the opinion of the Court with respect to Parts I, II, and VI, in which BURGER, C. J., and BRENNAN, MARSHALL, BLACKMUN, and STEVENS, JJ., joined, and an opinion with respect to Parts III, IV, and V, in which BURGER, C. J., joined. BLACKMUN, J., filed an opinion concurring in part and dissenting in part, in which BRENNAN, MARSHALL, and STEVENS, JJ., joined. O'CONNOR, J., filed an opinion concurring in part in the judgment and dissenting in part, in which WHITE and REHNQUIST, JJ., joined.

SUPREME COURT OF THE UNITED STATES

No. 81–185

CHRIS SIMOPOULOS, APPELLANT *v.* VIRGINIA

ON APPEAL FROM THE SUPREME COURT OF VIRGINIA

[June 15, 1983]

JUSTICE STEVENS, dissenting.

Prior to this Court's decision in *Roe* v. *Wade*, 410 U. S. 113 (1973), it was a felony to perform any abortion in Virginia except in a hospital accredited by the Joint Committee on Accreditation of Hospitals and licensed by the Department of Health, and with the approval of the hospital's Abortion Review Board (a committee of three physicians).* In 1975, the Virginia Code was amended to authorize additional abortions, including any second trimester abortion performed by a physician "in a hospital licensed by the State Department of Health or under the control of the State Board of Mental Health and Mental Retardation." Va. Code § 18.2–73 (1982).

The amended statute might be interpreted in either of two ways. It might be read to prohibit all second trimester abortions except those performed in a full-service, acute-care hospital facility. Or it might be read to permit any abortion performed in a facility licensed as a "hospital" in accord with any regulations subsequently adopted by the Department of Health. The Court today chooses the latter interpretation. See *ante*, at 5–6.

*An in-hospital abortion was also unlawful unless (a) it was necessary to protect the life or health of the mother, (b) the pregnancy was the product of rape or incest, or (c) there was a substantial medical likelihood that the child would be born with an irremediable and incapacitating mental or physical defect. 1970 Va. Acts, ch. 508.

There is reason to think the Court may be wrong. At the time the statute was enacted, there were no regulations identifying abortion clinics as "hospitals." The structure of the 1975 amendment suggests that the Virginia General Assembly did not want to make any greater change in its law than it believed necessary to comply with *Roe* v. *Wade*, and it may well have thought a full-service acute-care hospitalization requirement constitutionally acceptable. Moreover, the opinion below does not suggest that the Supreme Court of Virginia believed the term "hospital" to incorporate licensed abortion clinics. It only discussed testimony pertaining to full-service, acute-care hospitals like Fairfax Hospital. See Juris. Statement 16a. And it stated that "two hospitals in Northern Virginia and 24 hospitals located elsewhere in the State were providing abortion services in 1977," Juris. Statement 19a, again referring to acute-care facilities. The opinion refers to "clinics" only once, as part of a general statement concerning the variety of medical care facilities the state licenses and regulates; even there, the term is included in the list as a category that is distinct from "hospitals." Juris. Statement 18a.

On the other hand, the Court may well be correct in its interpretation of the Virginia statute. The word "hospital" in § 18.2–73 could incorporate by reference any institution licensed in accord with Va. Code § 32.1–123.1 and its implementing regulations. See *ante*, at 5–6. It is not this Court's role, however, to interpret state law. We should not rest our decision on an interpretation of state law that was not endorsed by the court whose judgment we are reviewing. The Virginia Supreme Court's opinion was written on the assumption that the Commonwealth could constitutionally require all second trimester abortions to be performed in a full-service, acute-care hospital. Our decision today in *City of Akron* v. *Akron Center for Reproductive Health, Inc.*, *ante*, p. ——, proves that assumption to have been incorrect. The proper disposition of this appeal is therefore to vacate the

judgment of the Supreme Court of Virginia and to remand the case to that court to reconsider its holding in the light of our opinion in *Akron*.

I respectfully dissent.

NOTICE: This opinion is subject to formal revision before publication in the preliminary print of the United States Reports. Readers are requested to notify the Reporter of Decisions, Supreme Court of the United States, Washington, D. C. 20543, of any typographical or other formal errors, in order that corrections may be made before the preliminary print goes to press.

SUPREME COURT OF THE UNITED STATES

Nos. 81–746 AND 81–1172

CITY OF AKRON, PETITIONER

81–746 *v.*

AKRON CENTER FOR REPRODUCTIVE HEALTH, INC., ET AL.

AKRON CENTER FOR REPRODUCTIVE HEALTH, INC., ET AL., PETITIONERS

81–1172 *v.*

CITY OF AKRON ET AL.

ON WRITS OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

[June 15, 1983]

JUSTICE POWELL delivered the opinion of the Court.

In this litigation we must decide the constitutionality of several provisions of an ordinance enacted by the city of Akron, Ohio, to regulate the performance of abortions. Today we also review abortion regulations enacted by the State of Missouri, see *Planned Parenthood Ass'n of Kansas City, Mo., Inc.* v. *Ashcroft*, *post*, p. ——, and by the State of Virginia, see *Simopoulos* v. *Virginia*, *post*, p. ——.

These cases come to us a decade after we held in *Roe* v. *Wade*, 410 U. S. 113 (1973), that the right of privacy, grounded in the concept of personal liberty guaranteed by the Constitution, encompasses a woman's right to decide whether to terminate her pregnancy. Legislative responses to the Court's decision have required us on several occasions, and again today, to define the limits of a State's authority to

regulate the performance of abortions. And arguments continue to be made, in these cases as well, that we erred in interpreting the Constitution. Nonetheless, the doctrine of *stare decisis*, while perhaps never entirely persuasive on a constitutional question, is a doctrine that demands respect in a society governed by the rule of law.[1] We respect it today, and reaffirm *Roe* v. *Wade*.

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[1] There are especially compelling reasons for adhering to *stare decisis* in applying the principles of *Roe* v. *Wade*. That case was considered with special care. It was first argued during the 1971 Term, and reargued—with extensive briefing—the following Term. The decision was joined by the Chief Justice and six other Justices. Since *Roe* was decided in February 1973, the Court repeatedly and consistently has accepted and applied the basic principle that a woman has a fundamental right to make the highly personal choice whether or not to terminate her pregnancy. See *Connecticut* v. *Menillo*, 423 U. S. 9 (1975); *Planned Parenthood of Central Mo.* v. *Danforth*, 428 U. S. 52 (1976); *Bellotti* v. *Baird*, 428 U. S. 132 (1976); *Beal* v. *Doe*, 432 U. S. 438 (1977); *Maher* v. *Roe*, 432 U. S. 464 (1977); *Colautti* v. *Franklin*, 439 U. S. 379 (1979); *Bellotti* v. *Baird*, 443 U. S. 622 (1979); *Harris* v. *McRae*, 448 U. S. 297 (1980); *H.L.* v. *Matheson*, 450 U. S. 398 (1981).

Today, however, the dissenting opinion rejects the basic premise of *Roe* and its progeny. The dissent stops short of arguing flatly that *Roe* should be overruled. Rather, it adopts reasoning that, for all practical purposes, would accomplish precisely that result. The dissent states that "[e]ven assuming that there is a fundamental right to terminate pregnancy in some situations," the State's compelling interests in maternal health and potential human life "are present *throughout* pregnancy." *Post*, at 8 (emphasis in original). The existence of these compelling interests turns out to be largely unnecessary, however, for the dissent does not think that even one of the numerous abortion regulations at issue imposes a sufficient burden on the "limited" fundamental right, *post*, at 15, n. 10, to require heightened scrutiny. Indeed, the dissent asserts that, regardless of cost, "[a] health regulation, such as the hospitalization requirement, simply does not rise to the level of 'official interference' with the abortion decision." *Post*, at 16 (quoting *Harris* v. *McRae*, 448 U. S. 297, 328 (1980) (WHITE, J., concurring)). The dissent therefore would hold that a requirement that all abortions be performed in an acute-care, general hospital does not impose an unacceptable burden on the abortion decision. It requires no great familiarity with the cost and limited availability of such hospitals to appreciate that the effect of the dissent's views would be to drive the performance

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In February 1978 the city council of Akron enacted Ordinance No. 160–1978, entitled "Regulation of Abortions."[2] The ordinance sets forth 17 provisions that regulate the per-

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of many abortions back underground free of effective regulation and often without the attendance of a physician.

In sum, it appears that the dissent would uphold virtually any abortion regulation under a rational-basis test. It also appears that even where heightened scrutiny is deemed appropriate, the dissent would uphold virtually any abortion-inhibiting regulation because of the State's interest in preserving potential human life. See *post*, at 23 (arguing that a 24-hour waiting period is justified in part because the abortion decision "has grave consequences for the fetus"). This analysis is wholly incompatible with the existence of the fundamental right recognized in *Roe* v. *Wade*.

[2]The ordinance was prefaced by several findings:

"WHEREAS, the citizens of Akron are entitled to the highest standard of health care; and

WHEREAS, abortion is a major surgical procedure which can result in complications, and adequate equipment and personnel should be required for its safe performance in order to insure the highest standards of care for the protection of the life and health of the pregnant woman; and

WHEREAS, abortion should be performed only in a hospital or in such other special outpatient facility offering the maximum safeguards to the life and health of the pregnant woman; and

WHEREAS, it is the finding of Council that there is no point in time between the union of sperm and egg, or at least the blastocyst stage and the birth of the infant at which point we can say the unborn child is not a human life, and that the changes occurring between implantation, a six-weeks embryo, a six-month fetus, and a one-week-old child, or a mature adult are merely stages of development and maturation; and

WHEREAS, traditionally the physician has been responsible for the welfare of both the pregnant woman and her unborn child, and that while situations of conflict may arise between a pregnant woman's health interests and the welfare of her unborn child, the resolution of such conflicts by inducing abortion in no way implies that the physician has an adversary relationship towards the unborn child; and

WHEREAS, Council therefore wishes to affirm that the destruction of the unborn child is not the primary purpose of abortion and that consequently Council recognizes a continuing obligation on the part of the physician towards the survival of a viable unborn child where this obligation can be discharged without additional hazard to the health of the pregnant woman; and

formance of abortions, see Akron Codified Ordinances ch. 1870, five of which are at issue in this case:

(i) Section 1870.03 requires that all abortions performed after the first trimester of pregnancy be performed in a hospital.[3]

(ii) Section 1870.05 sets forth requirements for notification of and consent by parents before abortions may be performed on unmarried minors.[4]

(iii) Section 1870.06 requires that the attending physician

WHEREAS, Council, after extensive public hearings and investigations concludes that enactment of this ordinance is a reasonable and prudent action which will significantly contribute to the preservation of the public life, health, safety, morals, and welfare." Akron Ordinance No. 160–1978.

[3] "1870.03 ABORTION IN HOSPITAL

No person shall perform or induce an abortion upon a pregnant woman subsequent to the end of the first trimester of her pregnancy, unless such abortion is performed in a hospital."

Section 1870.1(B) defines "hospital" as "a general hospital or special hospital devoted to gynecology or obstetrics which is accredited by the Joint Commission on Accreditation of Hospitals or by the American Osteopathic Association."

[4] "1870.05 NOTICE AND CONSENT

(A) No physician shall perform or induce an abortion upon an unmarried pregnant woman under the age of 18 years without first having given at least twenty-four (24) hours actual notice to one of the parents or the legal guardian of the minor pregnant woman as to the intention to perform such abortion, or if such parent or guardian cannot be reached after a reasonable effort to find him or her, without first having given at least seventy-two (72) hours constructive notice to one of the parents or the legal guardian of the minor pregnant woman by certified mail to the last known address of one of the parents or guardian, computed from the time of mailing, unless the abortion is ordered by a court having jurisdiction over such minor pregnant woman.

(B) No physician shall perform or induce an abortion upon a minor pregnant woman under the age of fifteen (15) years without first having obtained the informed written consent of the minor pregnant woman in accordance with Section 1870.06 of this Chapter, and

(1) First having obtained the informed written consent of one of her parents or her legal guardian in accordance with Section 1870.06 of this Chapter, or

(2) The minor pregnant woman first having obtained an order from a court having jurisdiction over her that the abortion be performed or induced."

make certain specified statements to the patient "to insure that the consent for an abortion is truly informed consent."[5]

(iv) Section 1870.07 requires a 24-hour waiting period between the time the woman signs a consent form and the time the abortion is performed.[6]

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[5] "1870.06 INFORMED CONSENT

(A) An abortion otherwise permitted by law shall be performed or induced only with the informed written consent of the pregnant woman, and one of her parents or her legal guardian whose consent is required in accordance with Section 1870.05(B) of this Chapter, given freely and without coercion.

(B) In order to insure that the consent for an abortion is truly informed consent, an abortion shall be performed or induced upon a pregnant woman only after she, and one of her parents or her legal guardian whose consent is required in accordance with Section 1870.05(B) of this Chapter, have been orally informed by her attending physician of the following facts, and have signed a consent form acknowledging that she, and the parent or legal guardian where applicable, have been informed as follows:

(1) That according to the best judgment of the attending physician she is pregnant.

(2) The number of weeks elapsed from the probable time of conception of her unborn child, based upon the information provided by her as to the time of her last menstrual period and after a history and physical examination and appropriate laboratory test.

(3) That the unborn child is a human life from the moment of conception and that there has been described in detail the anatomical and physiological characteristics of the particular unborn child at the gestational point of development at which time the abortion is to be performed, including, but not limited to, appearance, mobility, tactile sensitivity, including pain, perception or response, brain and heart function, the presence of internal organs and the presence of external members.

(4) That her unborn child may be viable, and thus capable of surviving outside of her womb, if more than twenty-two (22) weeks have elapsed from the time of conception, and that her attending physician has a legal obligation to take all reasonable steps to preserve the life and health of her viable unborn child during the abortion.

(5) That abortion is a major surgical procedure, which can result in serious complications, including hemorrhage, perforated uterus, infection, menstrual disturbances, sterility and miscarriage and prematurity in subsequent pregnancies; and that abortion may leave essentially unaffected or may worsen any existing psychological problems she may have, and can result in severe emotional disturbances.

(6) That numerous public and private agencies and services are available

[Footnotes 6 and 7 are on page 6]

(v) Section 1870.16 requires that fetal remains be "disposed of in a humane and sanitary manner."[7]

A violation of any section of the ordinance is punishable as a criminal misdemeanor. § 1870.18. If any provision is invalidated, it is to be severed from the remainder of the ordinance.[8] The ordinance became effective on May 1, 1978.

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to provide her with birth control information, and that her physician will provide her with a list of such agencies and the services available if she so requests.

(7) That numerous public and private agencies and services are available to assist her during pregnancy and after the birth of her child, if she chooses not to have the abortion, whether she wishes to keep her child or place him or her for adoption, and that her physician will provide her with a list of such agencies and the services available if she so requests.

(C) At the same time the attending physician provides the information required by paragraph (B) of this Section, he shall, at least orally, inform the pregnant woman, and one of her parents or her legal guardian whose consent is required in accordance with Section 1870.05(B) of this Chapter, of the particular risks associated with her own pregnancy and the abortion technique to be employed including providing her with at least a general description of the medical instructions to be followed subsequent to the abortion in order to insure her safe recovery, and shall in addition provide her with such other information which in his own medical judgment is relevant to her decision as to whether to have an abortion or carry her pregnancy to term.

(D) The attending physician performing or inducing the abortion shall provide the pregnant woman, or one of her parents or legal guardian signing the consent form where applicable, with a duplicate copy of the consent form signed by her, and one of her parents or her legal guardian where applicable, in accordance with paragraph (B) of this Section."

[6] "1870.07 WAITING PERIOD

No physician shall perform or induce an abortion upon a pregnant woman until twenty-four (24) hours have elapsed from the time the pregnant woman, and one of her parents or her legal guardian whose consent is required in accordance with Section 1870.05(B) of this Chapter, have signed the consent form required by Section 1870.06 of this Chapter, and the physician so certifies in writing that such time has elapsed."

[7] "1870.16 DISPOSAL OF REMAINS

Any physician who shall perform or induce an abortion upon a pregnant woman shall insure that the remains of the unborn child are disposed of in a humane and sanitary manner."

[8] "1870.19 SEVERABILITY

Should any provision of this Chapter be construed by any court of law to

On April 19, 1978, a lawsuit challenging virtually all of the ordinance's provisions was filed in the District Court for the Northern District of Ohio. The plaintiffs, respondents and cross-petitioners in this Court, were three corporations that operate abortion clinics in Akron and a physician who has performed abortions at one of the clinics. The defendants, petitioners and cross-respondents here, were the city of Akron and three city officials ("Akron"). Two individuals ("intervenors") were permitted to intervene as co-defendants "in their individual capacity as parents of unmarried daughters of child-bearing age." 479 F. Supp. 1172, 1181 (ND Ohio 1979). On April 27, 1978, the District Court preliminarily enjoined enforcement of the ordinance.

In August 1979, after hearing evidence, the District Court ruled on the merits. It found that plaintiffs lacked standing to challenge seven provisions of the ordinance, none of which is before this Court. The District Court invalidated four provisions, including § 1870.05 (parental notice and consent), § 1870.06(B) (requiring disclosure of facts concerning the woman's pregnancy, fetal development, the complications of abortion, and agencies available to assist the woman), and § 1870.16 (disposal of fetal remains). The court upheld the constitutionality of the remainder of the ordinance, including § 1870.03 (hospitalization for abortions after the first trimester), § 1870.06(C) (requiring disclosure of the particular risks of the woman's pregnancy and the abortion technique to be employed), and § 1870.07 (24-hour waiting period).

All parties appealed some portion of the District Court's judgment. The Court of Appeals for the Sixth Circuit affirmed in part and reversed in part. 651 F. 2d 1198 (1981). It affirmed the District Court's decision that § 1870.03's hospitalization requirement is constitutional. It also affirmed

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be invalid, illegal, unconstitutional, or otherwise unenforcible, such invalidity, illegality, unconstitutionality, or unenforcibility shall not extend to any other provision or provisions of this Chapter."

the ruling that §§ 1870.05, 1870.06(B), and 1870.16 are unconstitutional. The Court of Appeals reversed the District Court's decision on §§ 1870.06(C) and 1870.07, finding these provisions to be unconstitutional.

Three separate petitions for certiorari were filed. In light of the importance of the issues presented, and in particular the conflicting decisions as to whether a State may require that all second-trimester abortions be performed in a hospital,[9] we granted both Akron's and the plaintiffs' petitions. 456 U. S. 988 (1982). We denied the intervenors' petition, *Seguin* v. *Akron Center for Reproductive Health, Inc.*, 456 U. S. 989 (1982), but they have participated in this Court as respondents under our Rule 19.6. We now reverse the judgment of the Court of Appeals upholding Akron's hospitalization requirement, but affirm the remainder of the decision invalidating the provisions on parental consent, informed consent, waiting period, and disposal of fetal remains.

II

In *Roe* v. *Wade*, the Court held that the "right of privacy, . . . founded in the Fourteenth Amendment's concept of personal liberty and restrictions upon state action, . . . is broad enough to encompass a woman's decision whether or not to terminate her pregnancy." 410 U. S., at 153. Although the Constitution does not specifically identify this right, the history of this Court's constitutional adjudication leaves no doubt that "the full scope of the liberty guaranteed by the Due Process Clause cannot be found in or limited by the precise terms of the specific guarantees elsewhere provided in

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[9] Compare *Planned Parenthood Assn. of Kansas City, Mo., Inc.* v. *Ashcroft*, 655 F. 2d 848 (CA8), supplemented, 664 F. 2d 687 (CA8 1981) (invalidating hospital requirement), with *Simopoulos* v. *Commonwealth*, 221 Va. 1059, 277 S. E. 2d 194 (1981) (upholding hospital requirement). Numerous States require that second-trimester abortions be performed in hospitals. See Brief for Americans United for Life as *Amicus Curiae* in No. 81–185, at 4 n. 1 (listing 23 States).

the Constitution." *Poe* v. *Ullman*, 367 U. S. 497, 543 (1961) (Harlan, J., dissenting from dismissal of appeal). Central among these protected liberties is an individual's "freedom of personal choice in matters of marriage and family life." *Roe*, 410 U. S., at 169 (Stewart, J., concurring). See, *e. g.*, *Eisenstadt* v. *Baird*, 405 U. S. 438 (1972); *Loving* v. *Virginia*, 388 U. S. 1 (1967); *Griswold* v. *Connecticut*, 381 U. S. 479 (1965); *Pierce* v. *Society of Sisters*, 268 U. S. 510 (1925); *Meyer* v. *Nebraska*, 262 U. S. 390 (1923). The decision in *Roe* was based firmly on this long-recognized and essential element of personal liberty.

The Court also has recognized, because abortion is a medical procedure, that the full vindication of the woman's fundamental right necessarily requires that her physician be given "the room he needs to make his best medical judgment." *Doe* v. *Bolton*, 410 U. S. 179, 192 (1973). See *Whalen* v. *Roe*, 429 U. S. 589, 604–605, n. 33 (1977). The physician's exercise of this medical judgment encompasses both assisting the woman in the decisionmaking process and implementing her decision should she choose abortion. See *Colautti* v. *Franklin*, 439 U. S. 379, 387 (1979).

At the same time, the Court in *Roe* acknowledged that the woman's fundamental right "is not unqualified and must be considered against important state interests in abortion." *Roe*, 410 U. S., at 154. But restrictive state regulation of the right to choose abortion, as with other fundamental rights subject to searching judicial examination, must be supported by a compelling state interest. *Id.*, at 155. We have recognized two such interests that may justify state regulation of abortions.[10]

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[10] In addition, the Court repeatedly has recognized that, in view of the unique status of children under the law, the States have a "significant" interest in certain abortion regulations aimed at protecting children "that is not present in the case of an adult." *Planned Parenthood of Central Mo.* v. *Danforth*, 428 U. S. 52, 75 (1976). See *Carey* v. *Population Services International*, 431 U. S. 678, 693, n. 15 (1977) (plurality opinion). The

First, a State has an "important and legitimate interest in protecting the potentiality of human life." *Id.*, at 162. Although this interest exists "throughout the course of the woman's pregnancy," *Beal* v. *Doe*, 432 U. S. 438, 446 (1977), it becomes compelling only at viability, the point at which the fetus "has the capability of meaningful life outside the mother's womb," *Roe*, 410 U. S., at 163. See *Planned Parenthood of Central Mo.* v. *Danforth*, 428 U. S. 52, 63–65 (1976). At viability this interest in protecting the potential life of the unborn child is so important that the State may proscribe abortions altogether, "except when it is necessary to preserve the life or health of the mother." *Roe*, 410 U. S., at 164.

Second, because a State has a legitimate concern with the health of women who undergo abortions, "a State may properly assert important interests in safeguarding health [and] in maintaining medical standards." *Id.*, at 154. We held in *Roe*, however, that this health interest does not become compelling until "approximately the end of the first trimester" of pregnancy.[11] *Id.*, at 163. Until that time, a pregnant

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right of privacy includes "independence in making certain kinds of important decisions," *Whalen* v. *Roe*, 429 U. S. 589, 599–600 (1977), but this Court has recognized that many minors are less capable than adults of making such important decisions. See *Bellotti* v. *Baird*, 443 U. S. 622, 633–635 (1979) (plurality opinion) (*Bellotti II*); *Danforth*, *supra*, at 102 (STEVENS, J., concurring in part and dissenting in part). Accordingly, we have held that the States have a legitimate interest in encouraging parental involvement in their minor children's decision to have an abortion. See *H.L.* v. *Matheson*, 450 U. S. 398 (1981) (parental notice); *Bellotti II*, *supra*, at 639, 648 (plurality opinion) (parental consent). A majority of the Court, however, has indicated that these state and parental interests must give way to the constitutional right of a mature minor or of an immature minor whose best interests are contrary to parental involvement. See, *e. g.*, *Matheson*, *supra*, at 420 (POWELL, J., concurring); *id.*, at 450–451 (MARSHALL, J., dissenting). The plurality in *Bellotti II* concluded that a State choosing to encourage parental involvement must provide an alternative procedure through which a minor may demonstrate that she is mature enough to make her own decision or that the abortion is in her best interest. See *Bellotti II*, *supra*, at 643–644.

[11] *Roe* identified the end of the first trimester as the compelling point

woman must be permitted, in consultation with her physician, to decide to have an abortion and to effectuate that decision "free of interference by the State."[12] *Id.*, at 163.

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because until that time—according to the medical literature available in 1973—"mortality in abortion may be less than mortality in normal childbirth." 410 U. S., at 163. There is substantial evidence that developments in the past decade, particularly the development of a much safer method for performing second-trimester abortions, see *infra*, at 17–18, have extended the period in which abortions are safer than childbirth. See, *e. g.*, LeBolt, *et al.*, Mortality from Abortion and Childbirth: Are the Populations Comparable?, 248 J. A. M. A. 188, 191 (1982) (abortion may be safer than childbirth up to gestational ages of 16 weeks).

We think it prudent, however, to retain *Roe*'s identification of the beginning of the second trimester as the approximate time at which the State's interest in maternal health becomes sufficiently compelling to justify significant regulation of abortion. We note that the medical evidence suggests that until approximately the end of the first trimester, the State's interest in maternal health would not be served by regulations that restrict the manner in which abortions are performed by a licensed physician. See, *e. g.*, American College of Obstetricians and Gynecologists (ACOG), Standards for Obstetric-Gynecologic Services 54 (5th ed. 1982) (hereinafter ACOG Standards) (uncomplicated abortions generally may be performed in a physician's office or an outpatient clinic up to 14 weeks from the first day of the last menstrual period); ACOG Technical Bulletin No. 56, Methods of Mid-Trimester Abortion (Dec. 1979) ("Regardless of advances in abortion technology, midtrimester terminations will likely remain more hazardous, expensive, and emotionally disturbing for women than earlier abortions.").

The *Roe* trimester standard thus continues to provide a reasonable legal framework for limiting a State's authority to regulate abortions. Where the State adopts a health regulation governing the performance of abortions during the second trimester, the determinative question should be whether there is a reasonable medical basis for the regulation. See *Roe*, *supra*, at 163. The comparison between abortion and childbirth mortality rates may be relevant only where the State employs a health rationale as a justification for a complete prohibition on abortions in certain circumstances. See *Danforth*, 428 U. S., at 78–79 (invalidating state ban on saline abortions, a method that was "safer, with respect to maternal mortality, than even continuation of the pregnancy until normal childbirth").

[12] Of course, the State retains an interest in ensuring the validity of *Roe*'s factual assumption that "the first trimester abortion [is] as safe for the woman as normal childbirth at term," an assumption that "holds true only if the abortion is performed by medically competent personnel under conditions insuring maximum safety for the woman." *Connecticut* v. *Menillo*, 423 U. S. 9, 11 (1975) (*per curiam*). On this basis, for example, it

This does not mean that a State never may enact a regulation touching on the woman's abortion right during the first weeks of pregnancy. Certain regulations that have no significant impact on the woman's exercise of her right may be permissible where justified by important state health objectives. In *Danforth*, *supra*, we unanimously upheld two Missouri statutory provisions, applicable to the first trimester, requiring the woman to provide her informed written consent to the abortion and the physician to keep certain records, even though comparable requirements were not imposed on most other medical procedures. See 428 U. S., at 65–67, 79–81. The decisive factor was that the State met its burden of demonstrating that these regulations furthered important health-related State concerns.[13] But even these minor regulations on the abortion procedure during the first trimester may not interfere with physician-patient consultation or with the woman's choice between abortion and childbirth. See *id.*, at 81.

From approximately the end of the first trimester of pregnancy, the State "may regulate the abortion procedure to the extent that the regulation reasonably relates to the preservation and protection of maternal health."[14] *Roe*, 410 U. S., at 163. The State's discretion to regulate on this basis does not, however, permit it to adopt abortion regulations that

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is permissible for the States to impose criminal sanctions on the performance of an abortion by a nonphysician. *Ibid.*

[13] For example, we concluded that recordkeeping, "if not abused or overdone, can be useful to the State's interest in protecting the health of its female citizens, and may be a resource that is relevant to decisions involving medical experience and judgment." 428 U. S., at 81. See *infra*, at 24–26 (discussing the State's interest in requiring informed consent).

[14] "Examples of permissible state regulation in this area are requirements as to the qualifications of the person who is to perform the abortion; as to the licensure of that person; as to the facility in which the procedure is to be performed, that is, whether it must be a hospital or may be a clinic or some other place of less-than-hospital status; as to the licensing of the facility; and the like." *Roe*, 410 U. S., at 163–164.

depart from accepted medical practice. We have rejected a State's attempt to ban a particular second-trimester abortion procedure, where the ban would have increased the costs and limited the availability of abortions without promoting important health benefits. See *Danforth*, 428 U. S., at 77–78. If a State requires licensing or undertakes to regulate the performance of abortions during this period, the health standards adopted must be "legitimately related to the objective the State seeks to accomplish." *Doe*, 410 U. S., at 195.

III

Section 1870.03 of the Akron ordinance requires that any abortion performed "upon a pregnant woman subsequent to the end of the first trimester of her pregnancy"[15] must be "performed in a hospital." A "hospital" is "a general hospital or special hospital devoted to gynecology or obstetrics which is accredited by the Joint Commission on Accreditation of Hospitals or by the American Osteopathic Association." § 1870.1(B). Accreditation by these organizations requires compliance with comprehensive standards governing a wide variety of health and surgical services.[16] The ordinance thus

[15] The Akron ordinance does not define "first trimester," but elsewhere suggests that the age of the fetus should be measured from the date of conception. See § 1870.06(B)(2) (physician must inform woman of the number of weeks elapsed since conception); § 1870.06(B)(4) (physician must inform woman that a fetus may be viable after 22 weeks from conception). An average pregnancy lasts approximately 38 weeks from the time of conception or, as more commonly measured, 40 weeks from the beginning of the woman's last menstrual period. Under both methods there may be more than a two-week deviation either way.

Because of the approximate nature of these measurements, there is no certain method of delineating "trimesters." Frequently, the first trimester is estimated as 12 weeks following conception, or 14 weeks following the last menstrual period. We need not attempt to draw a precise line, as this Court—for purposes of analysis—has identified the "compelling point" for the State's interest in health as "approximately the end of the first trimester." *Roe*, 410 U. S., at 163. Unless otherwise indicated, all references in this opinion to gestational age are based on the time from the beginning of the last menstrual period.

[16] The Joint Commission on Accreditation of Hospitals (JCAH), for ex-

prevents the performance of abortions in outpatient facilities that are not part of an acute-care, full-service hospital.[17]

In the District Court plaintiffs sought to demonstrate that this hospitalization requirement has a serious detrimental impact on a woman's ability to obtain a second-trimester abortion in Akron and that it is not reasonably related to the State's interest in the health of the pregnant woman. The District Court did not reject this argument, but rather found the evidence "not . . . so convincing that it is willing to discard the Supreme Court's formulation in *Roe*" of a line between impermissible first-trimester regulation and permissible second-trimester regulation. 479 F. Supp., at 1215. The Court of Appeals affirmed on a similar basis. It accepted plaintiffs' argument that Akron's hospitalization requirement did not have a reasonable health justification during at least part of the second trimester, but declined to "retreat from the 'bright line' in *Roe* v. *Wade*." 651 F. 2d, at 1210.[18] We believe that the courts below misinterpreted this

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ample, has established guidelines for the following services: dietetic, emergency, home care, nuclear medicine, pharmaceutical, professional library, rehabilitation, social work, and special care. See generally JCAH, Accreditation Manual for Hospitals, 1983 Edition (1982).

[17] Akron's ordinance distinguishes between "hospitals" and outpatient clinics. Section 1870.02 provides that even first-trimester abortions must be performed in "a hospital or an abortion facility." "Abortion facility" is defined as "a clinic, physician's office, or any other place or facility in which abortions are performed, other than a hospital." § 1870.01(G).

[18] The Court of Appeals believed that it was bound by *Gary-Northwest Indiana Women's Services, Inc.* v. *Bowen*, 496 F. Supp. 894 (ND Ind. 1980) (three-judge court), aff'd *sub nom. Gary-Northwest Indiana Women's Services, Inc.* v. *Orr*, 451 U. S. 931 (1981), in which an Indiana second-trimester hospitalization requirement was upheld. Although the District Court in that case found that "*Roe* does not render the constitutionality of second trimester regulations subject to either the availability of abortions or the improvements in medical techniques and skills," 496 F. Supp., at 901–902, it also rested the decision on the alternative ground that the plaintiffs had failed to provide evidence to support their theory that it was unreasonable to require hospitalization for dilatation and evacuation abortions performed early in the second trimester. See *id.*, at 902–903. Our

Court's prior decisions, and we now hold that § 1870.03 is unconstitutional.

A

In *Roe* v. *Wade* the Court held that after the end of the first trimester of pregnancy the State's interest becomes compelling, and it may "regulate the abortion procedure to the extent that the regulation reasonably relates to the preservation and protection of maternal health." 410 U. S., at 163. We noted, for example, that States could establish requirements relating "to the facility in which the procedure is to be performed, that is, whether it must be in a hospital or may be a clinic or some other place of less-than-hospital status." *Ibid.* In the companion case of *Doe* v. *Bolton* the Court invalidated a Georgia requirement that all abortions be performed in a hospital licensed by the State Board of Health and accredited by the Joint Commission on Accreditation of Hospitals. See 410 U. S., at 201. We recognized the State's legitimate health interests in establishing, for second-trimester abortions, "standards for licensing all facilities where abortions may be performed." *Id.*, at 195. We found, however, that "the State must show more than [was shown in *Doe*] in order to prove that only the full resources of a licensed hospital, rather than those of some other appropriately licensed institution, satisfy these health interests." *Ibid.*[19]

We reaffirm today, see *supra*, at 10, n. 11, that a State's interest in health regulation becomes compelling at approxi-

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summary affirmance therefore is not binding precedent on the hospitalization issue. See *Illinois State Board of Elections* v. *Socialist Workers Party*, 440 U. S. 173, 180–181, 182–183 (1979).

[19] We also found that the additional requirement that the licensed hospital be accredited by the JCAH was "not 'based on differences that are reasonably related to the purposes of the Act in which it is found.'" *Doe*, 410 U. S., at 194 (quoting *Morey* v. *Doud*, 354 U. S. 457, 465 (1957)). We concluded that, in any event, Georgia's hospital requirement was invalid because it applied to first-trimester abortions.

mately the end of the first trimester. The existence of a compelling state interest in health, however, is only the beginning of the inquiry. The State's regulation may be upheld only if it is reasonably designed to further that state interest. See *Doe*, 410 U. S., at 195. And the Court in *Roe* did not hold that it always is reasonable for a State to adopt an abortion regulation that applies to the entire second trimester. A State necessarily must have latitude in adopting regulations of general applicability in this sensitive area. But if it appears that during a substantial portion of the second trimester the State's regulation "depart[s] from accepted medical practice," *supra*, at 12, the regulation may not be upheld simply because it may be reasonable for the remaining portion of the trimester. Rather, the State is obligated to make a reasonable effort to limit the effect of its regulations to the period in the trimester during which its health interest will be furthered.

B

There can be no doubt that § 1870.03's second-trimester hospitalization requirement places a significant obstacle in the path of women seeking an abortion. A primary burden created by the requirement is additional cost to the woman. The Court of Appeals noted that there was testimony that a second-trimester abortion costs more than twice as much in a hospital as in a clinic. See 651 F. 2d, at 1209 (in-hospital abortion costs $850–$900, whereas a dilatation-and-evacuation (D&E) abortion performed in a clinic costs $350–$400).[20] Moreover, the court indicated that second-trimester abortions were rarely performed in Akron hospitals. *Ibid.* (only

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[20] National statistics indicate a similar cost difference. In 1978 the average clinic charged $284 for a D&E abortion, whereas the average hospital charge was $435. The hospital charge did not include the physician's fee, which ran as high as $300. See Rosoff, The Availability of Second-Trimester Abortion Services in the United States, published in Second Trimester Abortion: Perspectives After a Decade of Experience 35 (Berger, Brenner & Keith eds. 1981) (hereinafter Second Trimester Abortion).

nine second-trimester abortions performed in Akron hospitals in the year before trial).[21] Thus, a second-trimester hospitalization requirement may force women to travel to find available facilities, resulting in both financial expense and additional health risk. It therefore is apparent that a second-trimester hospitalization requirement may significantly limit a woman's ability to obtain an abortion.

Akron does not contend that § 1870.03 imposes only an insignificant burden on women's access to abortion, but rather defends it as a reasonable health regulation. This position had strong support at the time of *Roe* v. *Wade*, as hospitalization for second-trimester abortions was recommended by the American Public Health Association (APHA), see *Roe*, 410 U. S., at 143–146, and the American College of Obstetricians and Gynecologists (ACOG), see Standards for Obstetric-Gynecologic Services 65 (4th ed. 1974). Since then, however, the safety of second-trimester abortions has increased dramatically.[22] The principal reason is that the D&E procedure is now widely and successfully used for second-trimester abortions.[23] The Court of Appeals found that there was "an abundance of evidence that D&E is the safest method of performing post-first trimester abortions today." 651 F. 2d, at 1209. The availability of the D&E procedure during the interval between approximately 12 and 16 weeks of pregnancy,

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[21] The Akron situation is not unique. In many areas of this country, few, if any, hospitals perform second-trimester abortions. See, *e. g.*, *Planned Parenthood of Kansas City, Mo., Inc.* v. *Ashcroft*, 664 F. 2d 687, 689 (CA8 1981) (second-trimester D&E abortions available at only one hospital in Missouri); *Wolfe* v. *Stumbo*, 519 F. Supp. 22, 23 (WD Ky. 1980) (no elective post-first-trimester abortion performed in Kentucky hospitals); *Margaret S.* v. *Edwards*, 488 F. Supp. 181, 192 (ED La. 1980) (no hospitals in Louisiana perform abortions after first trimester).

[22] The death-to-case ratio for all second-trimester abortions in this country fell from 14.4 deaths per 100,000 abortions in 1972 to 7.6 per 100,000 in 1977. See Tyler, *et al.*, Second-Trimester Induced Abortion in the United States, published in Second Trimester Abortion 17–20.

[23] At the time *Roe* was decided, the D&E procedure was used only to perform first-trimester abortions.

a period during which other second-trimester abortion techniques generally cannot be used,[24] has meant that women desiring an early second-trimester abortion no longer are forced to incur the health risks of waiting until at least the sixteenth week of pregnancy.

For our purposes, an even more significant factor is that experience indicates that D&E may be performed safely on an outpatient basis in appropriate nonhospital facilities. The evidence is strong enough to have convinced the APHA to abandon its prior recommendation of hospitalization for all second-trimester abortions:

> "Current data show that abortions occurring in the second trimester can be safely performed by the Dilatation and Evacuation (D and E) procedure. . . . Requirements that all abortions after 12 weeks of gestation be performed in hospitals increase the expense and inconvenience to the woman without contributing to the safety of the procedure." APHA Recommended Program Guide for Abortion Services (Revised 1979), 70 Am. J. Public Health 652, 654 (1980) (hereinafter APHA Recommended Guide).

Similarly, the ACOG no longer suggests that all second-trimester abortions be performed in a hospital. It recommends that abortions performed in a physician's office or outpatient clinic be limited to 14 weeks of pregnancy, but it indicates that abortions may be performed safely in "a hospital-based or in a free-standing ambulatory surgical facility, or in an outpatient clinic meeting the criteria required for a free-standing surgical facility," until 18 weeks of pregnancy. ACOG, Standards for Obstetric-Gynecologic Services 54 (5th ed. 1982).

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[24] Instillation procedures, the primary means of performing a second-trimester abortion before the development of D&E, generally cannot be performed until approximately the 16th week of pregnancy because until that time the amniotic sac is too small. See Grimes & Cates, Dilatation and Evacuation, published in Second Trimester Abortion 121.

These developments, and the professional commentary supporting them, constitute impressive evidence that—at least during the early weeks of the second trimester—D&E abortions may be performed as safely in an outpatient clinic as in a full-service hospital.[25] We conclude, therefore, that "present medical knowledge," *Roe*, 410 U. S., at 163, convincingly undercuts Akron's justification for requiring that *all* second-trimester abortions be performed in a hospital.[26]

Akron nonetheless urges that "[t]he fact that some mid-trimester abortions may be done in a minimally equipped clinic does not invalidate the regulation."[27] Brief for Respondents

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[25] See also *Planned Parenthood of Kansas City, Mo., Inc.* v. *Ashcroft*, 664 F. 2d 687, 690 n. 6 (CA8 1981) (discussing testimony by Dr. Willard Cates, Chief of Federal Abortion Surveillance for the National Centers for Disease Control, that D&E second-trimester abortions are as safely performed outside of hospitals up to the sixteenth week); APHA Recommended Guide 654 (out-patient D&E is safer than all in-hospital non-D&E abortion procedures during the second trimester).

[26] At trial Akron relied largely on the former position of the various medical organizations concerning hospitalization during the second trimester. See 651 F. 2d, at 1209. The revised position of the ACOG did not occur until after trial.

Akron also argues that the safety of nonhospital D&E abortions depends on adherence to minimum standards such as those adopted by ACOG for free-standing surgical facilities, see ACOG Standards 51–62, and that there is no evidence that plaintiffs' clinics operate in this manner. But the issue in this case is not whether these clinics would meet such standards if they were prescribed by the city. Rather, Akron has gone much further by banning all second-trimester abortions in all clinics, a regulation that does not reasonably further the city's interest in promoting health. We continue to hold, as we did in *Doe* v. *Bolton*, that a State may, "from and after the end of the first trimester, adopt standards for licensing all facilities where abortions may be performed so long as those standards are legitimately related to the objective the State seeks to accomplish." 410 U. S., at 194–195. This includes standards designed to correct any deficiencies that Akron reasonably believes exist in the clinics' present operation.

[27] The city thus implies that its hospital requirement may be sustained because it is reasonable as applied to later D&E abortions or to all second-trimester instillation abortions. We do not hold today that a State in no circumstances may require that some abortions be performed in a full-service hospital. Abortions performed by D&E are much safer, up to a point in the development of the fetus, than those performed by instillation meth-

in No. 81–1172, p. 19. It is true that a state abortion regulation is not unconstitutional simply because it does not correspond perfectly in all cases to the asserted state interest. But the lines drawn in a state regulation must be reasonable, and this cannot be said of § 1870.03. By preventing the performance of D&E abortions in an appropriate nonhospital setting, Akron has imposed a heavy, and unnecessary, burden on women's access to a relatively inexpensive, otherwise accessible, and safe abortion procedure.[28] Section 1870.03 has "the effect of inhibiting . . . the vast majority of abortions after the first 12 weeks," *Danforth*, 428 U. S., at 79, and therefore unreasonably infringes upon a woman's constitutional right to obtain an abortion.

IV

We turn next to § 1870.05(B), the provision prohibiting a physician from performing an abortion on a minor pregnant woman under the age of 15 unless he obtains "the informed written consent of one of her parents or her legal guardian" or unless the minor obtains "an order from a court having jurisdiction over her that the abortion be performed or induced." The District Court invalidated this provision because "[i]t does not establish a procedure by which a minor can avoid a parental veto of her abortion decision by demonstrating that her decision is, in fact, informed. Rather, it requires, in all cases, both the minor's informed consent and ei-

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ods. See Cates & Grimes, Morbidity and Mortality, published in Second Trimester Abortion 166–169. The evidence before us as to the need for hospitalization concerns only the D&E method performed in the early weeks of the second trimester. See 651 F. 2d, at 1208–1210.

[28] In the United States during 1978, 82.1% of all abortions from 13–15 weeks and 24.6% of all abortions from 16–20 weeks were performed by the D&E method. See Department of Health and Human Services, Centers for Disease Control, Abortion Surveillance: Annual Summary 1978, Table 14, at 43 (1980).

ther parental consent or a court order." 479 F. Supp., at 1201. The Court of Appeals affirmed on the same basis.[29]

The relevant legal standards are not in dispute. The Court has held that "the State may not impose a blanket provision . . . requiring the consent of a parent or person *in loco parentis* as a condition for abortion of an unmarried minor." *Danforth*, 428 U. S., at 74. In *Bellotti* v. *Baird*, 443 U. S. 622 (1979) (*Bellotti II*), a majority of the Court indicated that a State's interest in protecting immature minors will sustain a requirement of a consent substitute, either parental or judicial. See *id.*, at 640–642 (plurality opinion for four Justices); *id.*, at 656–657 (WHITE, J., dissenting) (expressing approval of absolute parental or judicial consent requirement). See also *Danforth*, 428 U. S., at 102–105 (STEVENS, J., concurring in part and dissenting in part). The *Bellotti II* plurality cautioned, however, that the State must provide an alternative procedure whereby a pregnant minor may demonstrate that she is sufficiently mature to make the abortion decision herself or that, despite her immaturity, an abortion would be in her best interests. 443 U. S., at 643–644. Under these decisions, it is clear that Akron may not make a blanket determination that *all* minors under the age of 15 are too immature to make this decision or that an abortion never may be in the minor's best interests without parental approval.

Akron's ordinance does not create expressly the alternative procedure required by *Bellotti II*. But Akron contends that the Ohio Juvenile Court will qualify as a "court having jurisdiction" within the meaning of § 1870.05(B), and that "it is not to be assumed that during the course of the juvenile proceedings the Court will not construe the ordinance in a manner consistent with the constitutional requirement of a determination of the minor's ability to make an informed con-

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[29] The Court of Appeals upheld § 1870.05(A)'s notification requirement. See 651 F. 2d, at 1206. The validity of this ruling has not been challenged in this Court.

sent." Brief for Petitioners in No. 81–746, p. 28. Akron concludes that the courts below should not have invalidated § 1870.05(B) on its face. The city relies on *Bellotti* v. *Baird*, 428 U. S. 132 (1976) (*Bellotti I*), in which the Court did not decide whether a State's parental consent provisions were unconstitutional as applied to mature minors, holding instead that "abstention is appropriate where an unconstrued state statute is susceptible of a construction by the state judiciary 'which might avoid in whole or in part the necessity for federal constitutional adjudication, or at least materially change the nature of the problem.'" *Id.*, at 146–147 (quoting *Harrison* v. *NAACP*, 360 U. S. 167, 177 (1959)). See also *H.L.* v. *Matheson*, 450 U. S. 398 (1981) (refusing to decide whether parental notice statute would be constitutional as applied to mature minors).[30]

We do not think that the abstention principle should have been applied here. It is reasonable to assume, as we did in *Bellotti I*, *supra*, and *Matheson*, *supra*, that a state court presented with a state statute specifically governing abortion consent procedures for pregnant minors will attempt to construe the statute consistently with constitutional requirements. This suit, however, concerns a municipal ordinance that creates no procedures for making the necessary determinations. Akron seeks to invoke the Ohio statute governing juvenile proceedings, but that statute neither mentions minors' abortions nor suggests that the Ohio Juvenile Court has authority to inquire into a minor's maturity or emancipa-

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[30] The Court's primary holding in *Matheson* was that the pregnant minor who questioned Utah's abortion consent requirement on the ground that it impermissibly applied to mature or emancipated minors lacked standing to raise that argument since she had not alleged that she or any member of her class was mature or emancipated. 450 U. S., at 406. No such standing problem exists here, however, as the physician plaintiff, who is subject to potential criminal liability for failure to comply with the requirements of § 1870.05(B), has standing to raise the claims of his minor patients. See *Danforth*, 428 U. S., at 62; *Doe* v. *Bolton*, 410 U. S., at 188–189; *Bellotti II*, 443 U. S., at 627 n. 5 (plurality opinion).

tion.[31] In these circumstances, we do not think that the Akron ordinance, as applied in Ohio juvenile proceedings, is reasonably susceptible of being construed to create an "opportunity for case-by-case evaluations of the maturity of pregnant minors." *Bellotti II*, 443 U. S., at 643, n. 23 (plurality opinion). We therefore affirm the Court of Appeals' judgment that § 1870.05(B) is unconstitutional.

V

The Akron ordinance provides that no abortion shall be performed except "with the informed written consent of the pregnant woman, . . . given freely and without coercion." § 1870.06(A). Furthermore, "in order to insure that the consent for an abortion is truly informed consent," the woman must be "orally informed by her attending physician" of the status of her pregnancy, the development of her fetus, the date of possible viability, the physical and emotional complications that may result from an abortion, and the availability of agencies to provide her with assistance and information

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[31] The Ohio Juvenile Court has jurisdiction over any child "alleged to be a juvenile traffic offender, delinquent, unruly, abused, neglected, or dependent." Ohio Rev. Code Ann. § 2151.23. The only category that arguably could encompass a pregnant minor desiring an abortion would be the "neglected" child category. A neglected child is defined as one "[w]hose parents, guardian or custodian neglects or refuses to provide him with proper or necessary subsistence, education, medical or surgical care, or other care necessary for his health, morals, or well being." § 2151.03. Even assuming that the Ohio courts would construe these provisions as permitting a minor to obtain judicial approval for the "proper or necessary . . . medical or surgical care" of an abortion, where her parents had refused to provide that care, the statute makes no provision for a mature or emancipated minor completely to avoid hostile parental involvement by demonstrating to the satisfaction of the court that she is capable of exercising her constitutional right to choose an abortion. On the contrary, the statute requires that the minor's parents be notified once a petition has been filed, § 2151.28, a requirement that in the case of a mature minor seeking an abortion would be unconstitutional. See *H.L.* v. *Matheson*, 450 U. S. 398, 420 (1981) (POWELL, J., concurring); *id.*, at 428, n. 3 (MARSHALL, J., dissenting).

with respect to birth control, adoption, and childbirth. § 1870.06(B). In addition, the attending physician must inform her "of the particular risks associated with her own pregnancy and the abortion technique to be employed . . . [and] other information which in his own medical judgment is relevant to her decision as to whether to have an abortion or carry her pregnancy to term." § 1870.06(C).

The District Court found that § 1870.06(B) was unconstitutional, but that § 1870.06(C) was related to a valid state interest in maternal health. See 479 F. Supp., at 1203–1204. The Court of Appeals concluded that both provisions were unconstitutional. See 651 F. 2d, at 1207. We affirm.

A

In *Danforth*, *supra*, we upheld a Missouri law requiring a pregnant woman to "certif[y] in writing her consent to the abortion and that her consent is informed and freely given and is not the result of coercion." 428 U. S., at 85. We explained:

> "The decision to abort . . . is an important, and often a stressful one, and it is desirable and imperative that it be made with full knowledge of its nature and consequences. The woman is the one primarily concerned, and her awareness of the decision and its significance may be assured, constitutionally, by the State to the extent of requiring her prior written consent." *Id.*, at 67.

We rejected the view that "informed consent" was too vague a term, construing it to mean "the giving of information to the patient as to just what would be done and as to its consequences. To ascribe more meaning than this might well confine the attending physician in an undesired and uncomfortable straitjacket in the practice of his profession." *Id.*, at 67, n. 8.

The validity of an informed consent requirement thus rests on the State's interest in protecting the health of the preg-

nant woman. The decision to have an abortion has "implications far broader than those associated with most other kinds of medical treatment," *Bellotti II*, 443 U. S., at 649 (plurality opinion), and thus the State legitimately may seek to ensure that it has been made "in the light of all attendant circumstances—psychological and emotional as well as physical—that might be relevant to the well-being of the patient." *Colautti* v. *Franklin*, 439 U. S. 379, 394 (1979).[32] This does not mean, however, that a State has unreviewable authority to decide what information a woman must be given before she chooses to have an abortion. It remains primarily the responsibility of the physician to ensure that appropriate information is conveyed to his patient, depending on her particular circumstances. *Danforth's* recognition of the State's interest in ensuring that this information be given will not justify abortion regulations designed to influence the woman's informed choice between abortion or childbirth.[33]

B

Viewing the city's regulations in this light, we believe that § 1870.06(B) attempts to extend the State's interest in ensuring "informed consent" beyond permissible limits. First, it is fair to say that much of the information required is designed not to inform the woman's consent but rather to per-

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[32] In particular, we have emphasized that a State's interest in protecting immature minors and in promoting family integrity gives it a special interest in ensuring that the abortion decision is made with understanding and after careful deliberation. See, *e. g.*, *H.L.* v. *Matheson*, 450 U. S. 398, 411 (1981); *id.*, at 419–420 (POWELL, J., concurring); *id.*, at 421–424 (STEVENS, J., concurring in judgment).

[33] A State is not always foreclosed from asserting an interest in whether pregnancies end in abortion or childbirth. In *Maher* v. *Roe*, 432 U. S. 464 (1977), and *Harris* v. *McRae*, 448 U. S. 297 (1980), we upheld governmental spending statutes that reimbursed indigent women for childbirth but not abortion. This legislation to further an interest in preferring childbirth over abortion was permissible, however, only because it did not add any "restriction on access to abortion that was not already there." *Maher*, 432 U. S., at 474.

suade her to withhold it altogether. Subsection (3) requires the physician to inform his patient that "the unborn child is a human life from the moment of conception," a requirement inconsistent with the Court's holding in *Roe* v. *Wade* that a State may not adopt one theory of when life begins to justify its regulation of abortions. See 410 U. S., at 159–162. Moreover, much of the detailed description of "the anatomical and physiological characteristics of the particular unborn child" required by subsection (3) would involve at best speculation by the physician.[34] And subsection (5), that begins with the dubious statement that "abortion is a major surgical procedure"[35] and proceeds to describe numerous possible physical and pyschological complications of abortion,[36] is a "parade of horribles" intended to suggest that abortion is a particularly dangerous procedure.

An additional, and equally decisive, objection to § 1870.06(B) is its intrusion upon the discretion of the pregnant woman's physician. This provision specifies a litany of information that the physician must recite to each woman regardless of whether in his judgment the information is relevant to her personal decision. For example, even if the phy-

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[34] This description must include, but not be limited to, "appearance, mobility, tactile sensitivity, including pain, perception or response, brain and heart function, the presence of internal organs and the presence of external members." The District Court found that "there was much evidence that it is impossible to determine many of [these] items, . . . such as the 'unborn child's' sensitivity to pain." 479 F. Supp., at 1203.

[35] The District Court found that "there was much evidence that rather than being 'a major surgical procedure' as the physician is required to state . . . , an abortion generally is considered a 'minor surgical procedure.'" 479 F. Supp., at 1203.

[36] Section 1870.06(B)(5) requires the physician to state

"That abortion is a major surgical procedure which can result in serious complications, including hemorrhage, perforated uterus, infection, menstrual disturbances, sterility and miscarriage and prematurity in subsequent pregnancies; and that abortion may leave essentially unaffected or may worsen any existing psychological problems she may have, and can result in severe emotional disturbances."

sician believes that some of the risks outlined in subsection (5) are nonexistent for a particular patient, he remains obligated to describe them to her. In *Danforth* the Court warned against placing the physician in just such an "undesired and uncomfortable straitjacket." 428 U. S., at 67, n. 8. Consistent with its interest in ensuring informed consent, a State may require that a physician make certain that his patient understands the physical and emotional implications of having an abortion. But Akron has gone far beyond merely describing the general subject matter relevant to informed consent. By insisting upon recitation of a lengthy and inflexible list of information, Akron unreasonably has placed "obstacles in the path of the doctor upon whom [the woman is] entitled to rely for advice in connection with her decision." *Whalen* v. *Roe*, 429 U. S. 589, 604 n. 33 (1977).[37]

C

Section 1870.06(C) presents a different question. Under this provision, the "attending physician" must inform the woman

> "of the particular risks associated with her own pregnancy and the abortion technique to be employed including providing her with at least a general description of

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[37] Akron has made little effort to defend the constitutionality of §§ 1870.06(B)(3), (4), and (5), but argues that the remaining four subsections of the provision are valid and severable. These four subsections require that the patient be informed by the attending physician of the fact that she is pregnant, § 1870.06(B)(1), the gestational age of the fetus, § 1870.06(B)(2), the availability of information on birth control and adoption, § 1870.06(B)(6), and the availability of assistance during pregnancy and after childbirth, § 1870.06(B)(7). This information, to the extent it is accurate, certainly is not objectionable, and probably is routinely made available to the patient. We are not persuaded, however, to sever these provisions from the remainder of § 1870.06(B). They require that all of the information be given orally by the attending physician when much, if not all of it, could be given by a qualified person assisting the physician. See *infra*, at 30–32.

> the medical instructions to be followed subsequent to the abortion in order to insure her safe recovery, and shall in addition provide her with such other information which in his own medical judgment is relevant to her decision as to whether to have an abortion or carry her pregnancy to term."

The information required clearly is related to maternal health and to the State's legitimate purpose in requiring informed consent. Nonetheless, the Court of Appeals determined that it interfered with the physician's medical judgment "in exactly the same way as section 1870.06(B). It requires the doctor to make certain disclosures in all cases, regardless of his own professional judgment as to the desirability of doing so." 651 F. 2d, at 1207. This was a misapplication of *Danforth*. There we construed "informed consent" to mean "the giving of information to the patient as to just what would be done and as to its consequences." 428 U. S., at 67 n. 8. We see no significant difference in Akron's requirement that the woman be told of the particular risks of her pregnancy and the abortion technique to be used, and be given general instructions on proper post-abortion care. Moreover, in contrast to subsection (B), § 1870.06(C) merely describes in general terms the information to be disclosed. It properly leaves the precise nature and amount of this disclosure to the physician's discretion and "medical judgment."

The Court of Appeals also held, however, that § 1870.06(C) was invalid because it required that the disclosure be made by the "attending physician." The court found that "the practice of all three plaintiff clinics has been for the counseling to be conducted by persons other than the doctor who performs the abortion," 651 F. 2d, at 1207, and determined that Akron had not justified requiring the physician personally to describe the health risks. Akron challenges this holding as contrary to our cases that emphasize the importance of the physician-patient relationship. In Akron's view, as in

the view of the dissenting judge below, the "attending physician" requirement "does no more than seek to ensure that there is in fact a true physician-patient relationship even for the woman who goes to an abortion clinic." 651 F. 2d, at 1217 (Kennedy, J., concurring in part and dissenting in part).

Requiring physicians personally to discuss the abortion decision, its health risks, and consequences with each patient may in some cases add to the cost of providing abortions, though the record here does not suggest that ethical physicians will charge more for adhering to this typical element of the physician-patient relationship. Yet in *Roe* and subsequent cases we have "stressed repeatedly the central role of the physician, both in consulting with the woman about whether or not to have an abortion, and in determining how any abortion was to be carried out." *Colautti* v. *Franklin*, 439 U. S. 379, 387 (1979). Moreover, we have left no doubt that, to ensure the safety of the abortion procedure, the States may mandate that only physicians perform abortions. See *Connecticut* v. *Menillo*, 423 U. S. 9, 11 (1975); *Roe*, 410 U. S., at 165.

We are not convinced, however, that there is as vital a state need for insisting that the physician performing the abortion, or for that matter any physician, personally counsel the patient in the absence of a request. The State's interest is in ensuring that the woman's consent is informed and unpressured; the critical factor is whether she obtains the necessary information and counseling from a qualified person, not the identity of the person from whom she obtains it.[38]

[38] We do not suggest that appropriate counseling consists simply of a recital of pertinent medical facts. On the contrary, it is clear that the needs of patients for information and an opportunity to discuss the abortion decision will vary considerably. It is not disputed that individual counseling should be available for those persons who desire or need it. See, *e. g.*, National Abortion Federation Standards 1 (1981) (hereinafter NAF Standards); Planned Parenthood of Metropolitan Washington, D. C., Inc., Guidelines for Operation, Maintenance, and Evaluation of First Trimester Outpatient Abortion Facilities 5 (1980). Such an opportunity may be

Akron and intervenors strongly urge that the nonphysician counselors at the plaintiff abortion clinics are not trained or qualified to perform this important function. The courts below made no such findings, however, and on the record before us we cannot say that the woman's consent to the abortion will not be informed if a physician delegates the counseling task to another qualified individual.

In so holding, we do not suggest that the State is powerless to vindicate its interest in making certain the "important" and "stressful" decision to abort "is made with full knowledge of its nature and consequences." *Danforth*, 428 U. S., at 67. Nor do we imply that a physician may abdicate his essential role as the person ultimately responsible for the medical aspects of the decision to perform the abortion.[39] A State may define the physician's responsibility to include verification that adequate counseling has been provided and that the woman's consent is informed.[40] In addition, the State may establish reasonable minimum qualifications for those people who perform the primary counseling function.[41] See, *e. g.*, *Doe*, 410 U. S., at 195 (State may require a medical facility

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especially important for minors alienated or separated from their parents. See APHA Recommended Guide 654. Thus, for most patients, mere provision of a printed statement of relevant information is not counseling.

[39] This Court's consistent recognition of the critical role of the physician in the abortion procedure has been based on the model of the competent, conscientious, and ethical physician. See *Doe*, 410 U. S., at 196–197. We have no occasion in this case to consider conduct by physicians that may depart from this model. Cf. *Danforth*, 428 U. S., at 91–92, n. 2 (Stewart, J., concurring).

[40] Cf. ACOG Standards 54 ("If counseling has been provided elsewhere, the physician performing the abortion should verify that the counseling has taken place.").

[41] The importance of well-trained and competent counselors is not in dispute. See, *e. g.*, APHA Recommended Guide 654 ("Abortion counselors may be highly skilled physicians as well as trained, sympathetic individuals working under appropriate supervision."); NAF Standards 2 (counselors must be trained initially at least in the following subjects: sexual and reproductive health; abortion technology; contraceptive technology; short-term counseling skills; community resources and referrals; informed consent; agency policies and practices.").

"to possess all the staffing and services necessary to perform an abortion safely"). In light of these alternatives, we believe that it is unreasonable for a State to insist that only a physician is competent to provide the information and counseling relevant to informed consent. We affirm the judgment of the Court of Appeals that § 1870.06(C) is invalid.

VI

The Akron ordinance prohibits a physician from performing an abortion until 24 hours after the pregnant woman signs a consent form. § 1870.07.[42] The District Court upheld this provision on the ground that it furthered Akron's interest in ensuring "that a woman's abortion decision is made after careful consideration of all the facts applicable to her particular situation." 479 F. Supp., at 1204. The Court of Appeals reversed, finding that the inflexible waiting period had "no medical basis," and that careful consideration of the abortion decision by the woman "is beyond the state's power to require." 651 F. 2d, at 1208. We affirm the Court of Appeals' judgment.

The District Court found that the mandatory 24-hour waiting period increases the cost of obtaining an abortion by requiring the woman to make two separate trips to the abortion facility. See 479 F. Supp., at 1204. Plaintiffs also contend that because of scheduling difficulties the effective delay may be longer than 24 hours, and that such a delay in some cases could increase the risk of an abortion. Akron denies that any significant health risk is created by a 24-hour waiting period, and argues that a brief period of delay—with the opportunity for reflection on the counseling received—often will be beneficial to the pregnant woman.

We find that Akron has failed to demonstrate that any le-

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[42] This provision does not apply if the physician certifies in writing that "there is an emergency need for an abortion to be performed or induced such that continuation of the pregnancy poses an immediate threat and grave risk to the life or physical health of the pregnant woman." § 1870.12.

gitimate state interest is furthered by an arbitrary and inflexible waiting period. There is no evidence suggesting that the abortion procedure will be performed more safely. Nor are we convinced that the State's legitimate concern that the woman's decision be informed is reasonably served by requiring a 24-hour delay as a matter of course. The decision whether to proceed with an abortion is one as to which it is important to "affor[d] the physician adequate discretion in the exercise of his medical judgment." *Colautti* v. *Franklin*, 439 U. S. 379, 387 (1979). In accordance with the ethical standards of the profession, a physician will advise the patient to defer the abortion when he thinks this will be beneficial to her.[43] But if a woman, after appropriate counseling, is prepared to give her written informed consent and proceed with the abortion, a State may not demand that she delay the effectuation of that decision.

VII

Section § 1870.16 of the Akron ordinance requires physicians performing abortions to "insure that the remains of the unborn child are disposed of in a humane and sanitary manner." The Court of Appeals found that the word "humane" was impermissibly vague as a definition of conduct subject to criminal prosecution. The court invalidated the entire provision, declining to sever the word "humane" in order to uphold the requirement that disposal be "sanitary." See 651 F. 2d, at 1211. We affirm this judgment.

Akron contends that the purpose of § 1870.16 is simply "'to preclude the mindless dumping of aborted fetuses on garbage piles.'" *Planned Parenthood Ass'n* v. *Fitzpatrick*, 401

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[43] The ACOG recommends that a clinic allow "sufficient time for reflection prior to making an informed decision." ACOG Standards 54. In contrast to § 1870.07's mandatory waiting period, this standard recognizes that the time needed for consideration of the decision varies depending on the particular situation of the patient and how much prior counseling she has received.

F. Supp. 554, 573 (ED Pa. 1975) (three-judge court) (quoting State's characterization of legislative purpose), aff'd mem. sub nom. *Franklin* v. *Fitzpatrick*, 428 U. S. 901 (1976).[44] It is far from clear, however, that this provision has such a limited intent. The phrase "humane and sanitary" does, as the Court of Appeals noted, suggest a possible intent to "mandate some sort of 'decent burial' of an embryo at the earliest stages of formation." 651 F. 2d, at 1211. This level of uncertainty is fatal where criminal liability is imposed. See *Colautti* v. *Franklin*, 439 U. S. 379, 396 (1979). Because § 1870.16 fails to give a physician "fair notice that his contemplated conduct is forbidden," *United States* v. *Harriss*, 347 U. S. 612, 617 (1954), we agree that it violates the Due Process Clause.[45]

VIII

We affirm the judgment of the Court of Appeals invalidating those sections of Akron's "Regulations of Abortions" ordinance that deal with parental consent, informed consent, a 24-hour waiting period, and the disposal of fetal remains. The remaining portion of the judgment, sustaining Akron's requirement that all second-trimester abortions be performed in a hospital, is reversed.

It is so ordered.

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[44] In *Fitzpatrick* the District Court accepted Pennsylvania's contention that its statute governing the "humane" disposal of fetal remains was designed only to prevent such "mindless dumping." That decision is distinguishable because the statute did not impose criminal liability, but merely provided for the promulgation of regulations to implement the disposal requirement. See 401 F. Supp., at 572–573.

[45] We are not persuaded by Akron's argument that the word "humane" should be severed from the statute. The uncertain meaning of the phrase "humane and sanitary" leaves doubt as to whether the city would have enacted § 1870.16 with the word "sanitary" alone. Akron remains free, of course, to enact more carefully drawn regulations that further its legitimate interest in proper disposal of fetal remains.

NOTE: Where it is feasible, a syllabus (headnote) will be released, as is being done in connection with this case, at the time the opinion is issued. The syllabus constitutes no part of the opinion of the Court but has been prepared by the Reporter of Decisions for the convenience of the reader. See *United States* v. *Detroit Lumber Co.*, 200 U. S. 321, 337.

SUPREME COURT OF THE UNITED STATES

Syllabus

CITY OF AKRON *v.* AKRON CENTER FOR REPRODUCTIVE HEALTH, INC., ET AL.

CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

No. 81–746. Argued November 30, 1982—Decided June 15, 1983*

An Akron, Ohio, ordinance, *inter alia*, (1) requires all abortions performed after the first trimester of pregnancy to be performed in a hospital (§ 1870.03); (2) prohibits a physician from performing an abortion on an unmarried minor under the age of 15 unless he obtains the consent of one of her parents or unless the minor obtains an order from a court having jurisdiction over her that the abortion be performed (§ 1870.05(B)); (3) requires that the attending physician inform his patient of the status of her pregnancy, the development of her fetus, the date of possible viability, the physical and emotional complications that may result from an abortion, and the availability of agencies to provide her with assistance and information with respect to birth control, adoption, and childbirth (§ 1870.06(B)), and also inform her of the particular risks associated with her pregnancy and the abortion technique to be employed (§ 1870.06(C)); (4) prohibits a physician from performing an abortion until 24 hours after the pregnant woman signs a consent form (§ 1870.07); and (5) requires physicians performing abortions to ensure that fetal remains are disposed of in a "human and sanitary manner" (§ 1870.16). A violation of the ordinance is punishable as a misdemeanor. Respondents and cross-petitioners filed an action in Federal District Court against petitioners and cross-respondents, challenging the ordinance. The District Court invalidated §§ 1870.05(B), 1870.06(B), and 1870.16, but upheld §§ 1870.03, 1870.06(C), and 1870.07. The Court of Appeals affirmed as to §§ 1870.03, 1870.05(B), 1870.06(B), and 1870.16, but reversed as to §§ 1870.06(C) and 1870.07.

Held:

1. Section 1870.03 is unconstitutional. Pp. 12–20.

(a) While a State's interest in health regulation becomes compelling

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*Together with No. 81–1172, *Akron Center for Reproductive Health, Inc., et al.* v. *City of Akron et al.*, also on certiorari to same court.

at approximately the end of the first trimester, the State's regulation may be upheld only if it is reasonably designed to further that interest. If during a substantial portion of the second trimester the State's regulation departs from accepted medical practice, it may not be upheld simply because it may be reasonable for the remaining portion of the trimester. Rather, the State is obligated to make a reasonable effort to limit the effect of its regulations to the period in the trimester during which its health interest may be furthered. Pp. 14–16.

(b) It cannot be said that the lines drawn in § 1870.03 are reasonable. By preventing the performance of dilatation-and-evacuation abortions in an appropriate nonhospital setting, Akron has imposed a heavy and unnecessary burden on women's access to a relatively inexpensive, otherwise accessible, and safe abortion procedure. Section 1870.03 has the effect of inhibiting the vast majority of abortions after the first trimester and therefore unreasonably infringes upon a woman's constitutional right to obtain an abortion. Pp. 16–20.

2. Section 1870.05(B) is unconstitutional as making a blanket determination that *all* minors under the age of 15 are too immature to make an abortion decision or that an abortion never may be in the minor's best interests without parental approval. Under circumstances where the Ohio statute governing juvenile proceedings does not mention minors' abortions nor suggest that the Ohio Juvenile Court has authority to inquire into a minor's maturity or emancipation, § 1870.05(B), as applied in juvenile proceedings, is not reasonably susceptible of being construed to create an opportunity for case-by-case evaluations of the maturity of pregnant minors. Pp. 20–23.

3. Sections 1870.06(B) and 1870.06(C) are unconstitutional. Pp. 23–31.

(a) The validity of an informed consent requirement rests on the State's interest in protecting the pregnant woman's health. But this does not mean that a State has unreviewable authority to decide what information a woman must be given before she chooses to have an abortion. A State may not adopt regulations designed to influence the woman's informed choice between abortion or childbirth. Pp. 24–25.

(b) Section 1870.06(B) attempts to extend the State's interest in ensuring "informed consent" beyond permissible limits, and intrudes upon the discretion of the pregnant woman's physician. While a State may require a physician to make certain that his patient understands the physical and emotional implications of having an abortion, § 1870.06(B) goes far beyond merely describing the general subject matter relevant to informed consent. By insisting upon recitation of a lengthy and inflexible list of information, the section unreasonably has placed obstacles in the path of the physician. Pp. 25–27.

Syllabus

(c) With respect to § 1870.06(C)'s requirement that the "attending physician" must inform the woman of the specified information, it is unreasonable for a State to insist that only a physician is competent to provide the information and counseling relevant to informed consent. Pp. 27–31.

4. Section 1870.07 is unconstitutional. Akron has failed to demonstrate that any legitimate state interest is furthered by an arbitrary and inflexible waiting period. There is no evidence that the abortion procedure will be performed more safely. Nor does it appear that the State's legitimate concern that the woman's decision be informed is reasonably served by requiring a 24-hour delay as a matter of course. Pp. 31–32.

5. Section 1870.16 violates the Due Process Clause by failing to give a physician fair notice that his contemplated conduct is forbidden. Pp. 32–33.

651 F. 2d 1198, affirmed in part and reversed in part.

POWELL, J., delivered the opinion of the Court, in which BURGER, C. J., and BRENNAN, MARSHALL, BLACKMUN, and STEVENS, JJ., joined. O'CONNOR, J., filed a dissenting opinion, in which WHITE and REHNQUIST, JJ., joined.